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# ORIGINAL DEPARTMENT.

## LECTURE.

### SYNOPSIS OF A LECTURE ON THE TREATMENT OF CHANCROID AND SYPHILIS.*

BY JOHN ASHHURST, JR., M. D.,
Of Philadelphia.

In introducing this subject, Dr. Ashhurst said that, as he believed that chancroid and syphilis had no connection with each other, except that they were commonly acquired under similar circumstances, it might seem strange that he should join them together in speaking of their treatment. The explanation, he said, was that two years ago, when he had had the honor to address the Society on the diagnosis of chancroid and syphilis, the Society requested that on some future occasion he would speak on the treatment of these two affections. In obedience to that request he had the honor to appear to-night.

#### THE TREATMENT OF CHANCROID AND SYPHILIS.

If any constitutional treatment is demanded in chancroid, it is such as is indicated by the general condition of the patient. Chancroid requires local treatment, but as syphilis is a constitutional affection, its treatment is constitutional or general. Local treatment is required for certain manifestations of syphilis, but the treatment, *par excellence*, is constitutional.

Speaking first of the treatment of chancroid, we may recognize three plans which have been adopted.

First, That form of treatment which aims to abolish the whole thing at once, that is, by excision. There are certain maladies in which, by this plan, we can get rid of the disease entirely, as in the case of certain tumors. So a local disease, which has begun in one or more spots, should theoretically be removable by cutting away the diseased tissue. This plan has, however, been tried and found wanting. The great objection to it is that the wound almost inevitably becomes inoculated by the chancroidal matter, and that the resulting sore is larger than the first one was, thus rendering the ultimate condition of the patient worse instead of better.

The second form of treatment, and that which I advocate, is one which aims not to remove the disease at once, but to favorably modify its future progress. This is the treatment by cauterization. By destroying the surface of the chancroidal ulcer, we remove its virulent qualities, and leave a healthy granulating sore. The caustic application removes the tendency to spread, and converts the ulcer into a healthy granulating surface. In speaking of this tendency to spread, I refer to one of the most prominent features of chancroid, its auto-inoculability, in which it differs from the initial lesion of syphilis. Chancroid is auto-inoculable indefinitely, and I believe that cauterization very much diminishes, if it does not destroy, this property. Although the pus from the chancroid is still contagious, it seems to lose, after cauterization, to a great extent, that quality which causes it to spread to other parts on the same person. In the choice of a caustic, my preference is for fuming nitric acid, applied by means of a piece of soft wood, such as the end of a match-stick. Another plan is to apply the acid by means of a glass brush, but I do not think this as desirable.

*Delivered before the Philadelphia County Medical Society, January 9, 1884.

Every cranny should be cauterized. Any part that escapes retains its quality of furnishing auto-inoculable pus, and the whole surface may return to its former condition; therefore, cauterization must be thorough if it is practiced at all. When the slough, produced by the caustic, separates; the surface soon granulates and heals; but the pus is contagious to the last. If the fear of pain deter the patient from submitting to cauterization, general anæsthesia may be properly employed, or the surgeon may first make an application of carbolic acid, which produces local anæsthesia, and apply the nitric acid afterwards. It may be necessary to repeat the operation.

There are other modes of effecting cauterization; one is the use of the carbo-sulphuric paste, recommended by French surgeons. This forms a crust, which I think is a disadvantage, as concealing the parts beneath. The solution of acid nitrate of mercury may be used, but if applied over an extensive surface it may cause salivation. It is not as well adapted to the purpose as nitric acid. The actual cautery also has strong advocates; it may be employed either with the simple hot iron, or with the Paquelin's or the galvanic cautery. These modes of cauterization are effective in cases of serpiginous chancroid—in the latter I think the hot iron the best application that can be made. The material used by many practitioners a few years ago, the nitrate of silver, is inefficient, and, in my judgment, has nothing to recommend it. Then for the after-dressing, after cauterization has been employed, we can use plain water, or lime-water, or black-wash, or a solution of salicylic acid, or what is known as the "nitric acid wash" (nitric acid f. ʒ j; water ℥ j), which is much used as a dressing in New York. When the chancroid is on a mucous surface, as in the female organs, or in any situation in which it is kept moist, a simple dry dressing of absorbent cotton or dry lint may be used; but where the chancroid is exposed, dry dressings are apt to become adherent, and wet applications are better. The dressing above all others which I think deserves attention, is iodoform. It is a comparatively recent remedy in these cases, and I think that it is the best application that can be made after thorough cauterization has been effected. It can be used in various ways, by simply dusting the finely-powdered drug over the surface, or as a wet dressing in the form of an alcoholic solution with glycerine, viz: Iodoform ʒ ss; alcohol f. ʒ ij; glycerine f. ʒ vj. Or it may be used in the form of an ointment, 15–30 grains to the ounce, or as an ethereal solution which evaporates, leaving a thin film of iodoform over the surface. An old remedy, which formerly had great reputation in these cases, was aromatic wine; but I do not think it is as efficient as iodoform. Another remedy, which is quite a novel one, is resorcin, an article of the phenol series. Great advantage has been claimed for it. Pyrogallic acid has also been used, as has the subnitrate of bismuth and various other dry powders. In the female, dressings, of course, must be applied with the aid of the speculum.

In chancroids at the meatus, I commonly use a solution of nitrate of silver (30 grs. to f. ʒ j.), since the contraction after the use of nitric acid might be objectionable in this situation. At the frænum some special precautions may be required. Deep cauterization here may be followed by bleeding, and it has been proposed to prevent this by the previous application of ligatures, tying the frænum above and below the seat of disease, or by employing the actual cautery. For chancroids beneath the prepuce, when this can be retracted, the best plan is to cauterize the sores and dress them in the ordinary way, either replacing the prepuce afterwards, or allowing it to stay retracted, as may be thought the most convenient. If, however, the prepuce cannot be retracted, then the surgeon may inject a strong solution of nitrate of silver, or, which I prefer when it can be done, may pack the space between the prepuce and the glans penis with lint saturated with a solution of nitrate of silver (gr. xx. to f. ʒ i.). Whenever it is necessary to circumcise the patient, of course the wound should be cauterized, as it will otherwise become inoculated and itself converted into a large chancroid. As for urethral chancroids, which are very rare, cauterization cannot be employed, as increasing the risk of stricture; absorbent cotton may be used as a dressing, taking care to have a thread attached by which the dressing may be withdrawn. About the rectum and anus, chancroids may be treated by cauterization, with the subsequent use of emollient enemata and opium suppositories. For the phagedænic chancroid, constitutional treatment is desirable, as in all other cases of phagedæna. Opium—one grain at night and one grain in the morning—is, I think, more beneficial than any other single remedy. In some cases it may be of advantage to remove the surface of a phagedænic or serpiginous chancroid by scraping with a scoop, and then using as a caustic, bromine, permanganate of potassium, or caustic potassa; but I think that the hot iron is the best local remedy in these cases. Syphilization has been used for chancroid, but it is of no value.

In regard to the principal complication of chancroid, the bubo, it may be of two kinds, the simple or inflammatory bubo, which is nothing but an adenitis, or the true chancroidal or virulent bubo. I believe it to be impossible when a bubo first makes its appearance, for the surgeon to say of which variety it is. Of late years I have seen many more examples of the simple than of the virulent bubo. Whether or not this is because the disease, like syphilis, is gradually becoming a milder affection than it was formerly, I cannot say.

In regard to the treatment of bubo, the surgeon should enforce rest in bed, if possible. Then counter-irritation should be employed very thoroughly. The best way is that suggested by Mr. Furneaux Jordan, of Birmingham, by applying the counter-irritant to the "next vascular area." The theory is that by irritating an adjacent part, the blood is caused to flow away from that originally affected. Counter-irritation is best effected by applying the tincture of iodine in the form of a broad horse-shoe around the inflamed gland, every day or every other day, so as to keep the part on the verge of vesication. The skin should, if possible, not be broken, but if it is so, some soothing ointment must be applied, and the use of iodine suspended for a few days. Over the bubo itself, the dressing which I have found most satisfactory consists of equal parts of belladonna and mercurial ointments; it is a simple resolvent and anodyne application, and is agreeable to the patient. I have also used an ointment of iodoform over the part, but do not think it as efficient as the belladonna and mercury; nor do I think the application of blisters as satisfactory as the use of iodine. Pressure is another remedy which may be properly employed when the bubo is not painful, but which is ill-adapted to the acute inflammatory stage. If it is to be employed, pressure may be effected by applying a shot-bag over the bubo while the patient is in bed; or by fastening a soft sponge over the part with a spica bandage applied with the thigh flexed on the trunk. If the bubo suppurates, of course it should be opened. Various plans have been suggested, but I do not think there is anything as efficient as a moderately free incision; and the direction in which this is made is a matter of considerable importance. I find that practitioners generally open buboes in the line of Poupart's ligament, but I think that an incision in the long axis of the patient's body is the best, supplemented, if necessary, by small transverse incisions on one or both sides. If the lips of the wound are kept apart, so as to allow the pus to flow out readily, the process of healing is much more rapid. Multiple punctures have been employed in opening buboes, and the introduction of a seton has also been suggested; in case phagadæna attacks the bubo, the use of the continuous hot bath has been proposed. My experience is here, too, in favor of the use of opium, locally and internally, and, if cauterization is necessary, the application of the hot iron. I think that there is an advantage, as regards the bubo, in a thorough cauterization of the original chancroid at the beginning. Bumstead and Taylor recommended that cauterization should be employed if it can be done in the first ten days; but if it is desirable in the first ten days, it seems to me to be proper at any period. These gentlemen believe that by early cauterization the patient will escape virulent bubo, and that even if an inflammatory bubo exists, its course will be favorably modified. I am aware that a directly contrary opinion is held by some surgeons, who believe that the risk of bubo is increased by cauterization; but, as far as my own experience goes, it confirms the teaching of Bumstead and Taylor.

If the surgeon is satisfied that he is dealing with a chancroidal or virulent bubo, simple incision is not sufficient. Here suppuration occurs first in the periglandular areolar tissue, and it is of great advantage to enucleate the infiltrated glands before they become disintegrated and inoculate the surrounding tissues with chancroidal matter. If the case is not seen until the whole wound has become inoculated, then I would slit up all sinuses, remove the thinned overhanging skin, and cauterize the whole surface with nitric acid, the patient being under the influence of ether.

The third plan of treatment, which is the fashionable treatment just now, is the use of simple dressings, such as I have advised for the after-treatment, without employing caustics. There is no doubt that healing will, in most of the mild, superficial chancroids met with at the present day, ultimately take place without cauterization; but I think the cure will be more certain, more rapid, and more likely to be free from complication, if the chancroid be cauterized in the way that I have recommended.

*Treatment of Syphilis.*—Syphilis is a constitutional affection, and demands constitutional treatment. The principal remedies are mercury and iodide of potassium. These have been given for many years, and yet it has never been satisfactorily determined in what way they produce their

effects. Probably it is safest to say that they act by eliminating the syphilitic poison and producing absorption of the gummatous and inflammatory deposits. No doubt, according to modern theories, they might be supposed to act by destroying syphilitic germs, but that suggestion opens questions in transcendental pathology into which this is not the time to enter.

For the convenience of considering the treatment of syphilis, we may divide its course into the primary, secondary, and tertiary stages.

The lesions of the primary stage are the initial lesion (or chancre) and the bubo which accompanies it. Now, in regard to the treatment of primary syphilis, I believe that the surgeon will do well to put his patient under mercurial treatment, provided that he is sure of his diagnosis. This view is opposed, however, by some authorities for whom I have great respect. My practice is to give mercury; and the best form in which it can be given, in the primary stage, is the green iodide or protiodide. I have been in the habit of prescribing this preparation in pills with opium alone, or made up with a confection of opium as an excipient: it has the advantage that it can be used a long while without causing salivation, and it is, moreover, efficient. I think that this is the safest mode of treating syphilis in the primary stage, but no patient should be placed on a mercurial course unless the surgeon is well satisfied that syphilis is actually present.

In regard to the local treatment of primary syphilis, the principal point is cleanliness; but local treatment is not of much value. Iodoform may be used as a dressing for the chancre, as it may for the ulcerative lesions met with in the later stages of syphilis. Cauterization is of no service. I do not believe that secondary symptoms were ever prevented by cauterizing a chancre.

There is another form of treatment which has some evidence in its favor, and that is the excision of the chancre.

Until within a few years the view of surgeons was that a chancre should not be excised except under special circumstances, as when occurring on an elongated prepuce; but within recent years the excision treatment has been revived, particularly in Germany, and in this country it has been advocated by Dr. White and others. To those who, like myself, take the view that syphilis is a constitutional disease from the beginning, and that the initial lesion, chancre, is but its first manifestation, of course the excision treatment seems somewhat unphilosophical. I have no personal experience in this form of treatment, but the weight of evidence, from what I have been able to read concerning it, seems to me to be against it. This, moreover, appears to be the prevailing view among the leading specialists in venereal affections in New York.

As regards the bubo of syphilis, no special treatment is required, though I have sometimes thought that I have derived advantage from the application of iodoform ointment.

In the treatment of the secondary stage of syphilis, of course mercury is the great remedy. Iodide of potassium is used by some surgeons in the primary stage, but for secondary syphilis all are agreed to use mercury. It should be used gradually, to prevent salivation on the one hand and intestinal irritation on the other. I think the best way in which it can be used is by inunction. I recommend the patient to rub ordinary mercurial ointment, or an ointment of the oleate of mercury, into the inner side of the thighs, using fifteen grains each morning and night, half a drachm altogether in the course of the day. If this seem too much, the remedy can be suspended for awhile, and then used in diminished doses. Another good plan is to apply the ointment to the soles of the feet, wearing woolen stockings; the place of application should be frequently changed, so as to avoid the occurrence of mercurial eczema. Before each application, too, the skin should be thoroughly washed and dried. In cases of infantile syphilis, Brodie's plan of putting the mercurial ointment on the belly-band is a good one.

If a patient objects to inunction, the mercury must be given by the mouth. The old-fashioned blue-pill is one of the most efficient preparations, if it is given cautiously; or the iodide may be used, or the bichloride, which, however, I think less useful than the others. Mercurial fumigation is a good method of treatment in certain obstinate forms of cutaneous syphilis, but is too troublesome for ordinary employment. Another mode of administering mercury is by hypodermic injections, usually of from $\frac{1}{12}$ to $\frac{3}{8}$ gr. of the corrosive chloride, though almost any preparation of mercury may be used hypodermically. I do not think that this plan presents enough advantages to counteract its disadvantages, and believe that it should be reserved for exceptional cases.

For mucous patches, constitutional treatment must, of course, be continued; and as a local remedy the solution of acid nitrate of mercury may be applied, being then followed by some simple dressing, such as black-wash, and iodoform afterwards. Another plan, recommended by Conradi,

is to use a strong solution of nitrate of silver, and then to apply metallic zinc. For syphilitic sore-throat, gargles of chlorate of potassium may be employed, or cauterizations with the liq. hydrarg. pernitratis; or dilute hydrochloric acid may be applied with an atomizer. For syphilitic iritis, I have been favorably impressed with Carmichael's mode of treatment, which consists in the administration of oil of turpentine in large doses. I have often used this with great advantage, but have on the other hand sometimes found it to fail, and have had to come back to mercury. The oil of turpentine is given in large doses (f. ʒj.) three times a day, in emulsion with gum and sugar, with a few drops of the tincture of opium to prevent strangury. The most important point in the treatment of iritis, however, is the local use of atropia. For alopecia, cantharidal washes may be recommended.

In the tertiary stage of syphilis, iodide of potassium is the chief remedy. Mercury is useful in the treatment of the dry eruptions and of interstitial orchitis, but not in the gummatous affections, where iodide of potassium is preferable. At the same time tonics must be given, as indeed in the secondary and primary stages also. An expectant plan of treatment has been suggested for syphilis, but it is not to be recommended, nor would I favor hygienic and tonic treatment by itself, though in connection with specific treatment it is of great value. A patient who leads a regular life, avoiding the use of tobacco and alcohol, and at the same time pursuing a proper course of treatment, has a better chance of recovery from syphilis than one who neglects hygienic measures.

In giving mercury for syphilis, there are two plans of proceeding: one in which small doses are given continuously for a long time, as particularly advised by Dr. Keyes, of New York; and the other, which seems to me more philosophical, in which the drug is given "*coup sur coup*," that is, in successive courses with intervening intervals. The doses should be moderate, and salivation should be avoided. The best way is to give mercury cautiously until the symptoms are relieved, or a few weeks longer, and then to suspend it altogether. Then, if there are any fresh symptoms, the administration may be renewed.

It has been proposed by Mr. Venning, as a test to determine when syphilis has been removed from the system, to examine the condition of the inguinal glands. If there is any induration remaining, the patient is still syphilitic.

Iodide of potassium may be used very freely in syphilis. Formerly, five-grain doses were ordinarily given, but from eight to ten grains is now considered a fair dose to begin with, and in some cases much larger quantities must be employed. I am convinced, however, that the drug is often given in excessive amounts in ordinary cases of syphilis. I do not recommend large doses unless the disease fails to respond to smaller ones, or unless the symptoms, as in some cases of cerebral syphilis, are immediately threatening to life. The iodide may be given simply in water, or with the compound syrup of sarsaparilla, or with fluid extract of gentian, viz.:

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|---|---|
| Pot. iod., | gr. viii.–x. |
| Ext. gent. fl., | ♏xv. |

With enough water to make a teaspoonful. Iodoform has been given internally, and homœopathic practitioners have employed gold, but neither appears to have any special value. Sarsaparilla used to be looked upon as an important remedy for syphilis, but I have never found that it was of any use whatever. A remedy strongly recommended by the late Dr. Sims was stillingia. Dr. Taylor speaks favorably of the erythroxylon coca. Hot baths are undoubtedly of use sometimes in syphilis. For hereditary syphilis, mercury and iodide of potassium, in doses suited to the age of the patient, and combined with tonics, and especially iron, are of use. If a syphilitic woman is pregnant, she should undergo a mercurial course, in hope of preventing infection of the fœtus.

## COMMUNICATIONS.

### THE LANCET VS. VERATRIA IN PNEUMONIA.

BY E. MICHENER, M. D.,
Of Toughkenamon, Pa.

I have often found that men, in their opinions and practices, are very much like *cranks*—I mean mechanical, not psychological cranks. All seem to have their *dead points;* and doctors are not an exception. While we can point out those dead points *in others*, we do not readily notice *our own;* we do not see ourselves as others see us. Hence, it is an act of kindness, indeed it becomes a *reciprocal duty* to point out and correct each other's weak points.

*Apropos.* (See Country Practitioner, March, 1881.) The editor, *E. P. Townsend, M. D.*, writes: "In view of the recent articles by *Dr. Hiram Corson*, in the MEDICAL AND SURGICAL REPORTER; also, one in the February number of this journal, by Dr. Ezra Michener; and a reprint in the present

number of one by Prof. S. D. Gross, upon the subject of blood-letting, each of whom refers to *pneumonia* as one of the diseases whose fatality has increased since blood-letting has gone out of fashing, I have thought it advisable to report the clinical notes of a case that occurred recently in my practice."

As *Dr. Townsend* was kind enough to indicate what he considered our *dead points* in the papers referred to, I would gladly have reciprocated the favor, but was physically unable at the time to do so, and the journal was soon after suspended. But I feel that the obligation still awaits an acknowledgment.

*Note.*—I can only and briefly notice this interesting case so far as it has relevancy to the "*Lost Art*" in similar cases.

*Dr. Townsend* says—on what authority I do not know—"That *they* bleed to reduce the power of the heart. (?) Then, why not reduce the power of the heart with *veratria*, and save the blood? What is the use of losing the blood, when the heart can be controlled just as well without it?" This, however, is a mere assumption of the points at issue. I demur, 1, That we do not bleed for this special purpose in pneumonia; and 2, His *ipse dixit* does not prove the assumption, that the object can be obtained just as well without it.

Again, "What kept up the engorgement of the lungs? The rapid action of the heart. And, evidently, the indication was to quiet the heart."

All this may have seemed conclusive to the author, and is expressed with an air of satisfaction. But, it may be asked, whether the congestion of the lungs did not *precede* the increased heart action? Whether the congestion did not still *persist* after the heart had been controlled by *veratria*? Whether a judicious bleeding would not have *relieved* alike both of the suffering organs?

No one, I suppose, will seriously deny that the heart was accelerated by a natural effort to *overcome* increased obstruction in the lungs. It is a *normal* action, where action is *adequate* to the purpose. We bleed to lessen the obstruction—to relieve the lungs of a *burden*, which they are *unable to carry*. For a practical illustration, I would refer the reader to *Dr. I. H. Stubbs' report* of my own case (MEDICAL AND SURGICAL REPORTER, July 8, 1882).

Other matters aside; the *death-roll* of this disease seems to indicate a fearful *era* when *veratria and whisky* were substituted for *blood-letting*.

But we are told "*that the patient had* ALL HIS BLOOD IN HIS VEINS—EXCEPT *what he had lost through the lungs.*" (!!!) Yes; and, pray, how much was that??? The doctor has not told us. But he has furnished data sufficient to *create a doubt* whether his patient was cured by *veratria*, or by the free and persistent *loss of blood*, kept up continuously, for *many days*. I can only give the data, leaving it for those who are more familiar with *veratria fluxions* to find the aggregate *amount* of blood that was lost or saved by the *economical procedure*. Thus:

January 11, 8 p. m. Sputa considerable, *rusty*, and *blood-streaked*.

January 12, 4 a. m. More free; containing *much more blood*.

January 12, 8 a. m. More profuse, and *more bloody*.

January 13. No report.

January 14, 8 a. m. Profuse.

January 15, 8 a. m. Sputa abundant and *sanguineous*.

January 16. Less profuse; *still bloody*.

January 22. Discharged.

If the patient possessed an abnormal quantity of blood, it could have been withdrawn with relief rather than prostration. If, on the contrary, agreeably to the *Bosses*, a man never has more than a normal quantity, it is worse than idle to say, "that his system was not called upon to manufacture thirty, or forty, ounces of blood to supply deficiencies."

If my clinical experience for sixty-eight years has taught me anything, it is this, that a judicious bleeding, on the first visit, would not have caused prostration, but would have reduced the disease to a *minimum* in duration and violence, and would have prevented, or greatly lessened, the *after-bleeding* from the lungs, and all other sources of exhaustion.

I have only noticed the *dead points* of the *crank*, which seemed to require a *balance-wheel* to carry them *safely over*.

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## PARTIAL OSSIFICATION OF THE UTERINE SURFACE OF THE PLACENTA.

BY W. H. DEARING, M. D.,
Of Malvern, Iowa.

Was called February 20, '83, to attend Mrs. S., age 21, in her first confinement. Fifteen hours after the pains first appeared she was delivered, per vias naturales, of a male child, whose weight was ten pounds. The first and second stages of labor were unaccompanied by accident. After waiting a proper length of time for the completion of the third stage without the desired result, I introduced my hand into the womb for the pur-

pose of ascertaining the cause of the non-delivery of the placenta. I admit I was somewhat mortified to find that I had a case of adhesion; but thinking it probably was of a simple form, and that a little time would bring around the desired result, I waited two hours without my expectations being realized. I then detached the placental mass slowly with the tips of my fingers, and finally brought it away. But upon examining the uterine surface of the placenta, I was greatly surprised to find it almost entirely ossified.

Dr. Dubois furnishes an instance of an abnormal adhesion of the placenta, in which the uterine surface was covered by an osseous or cretaceous substance; and Gooch reports that he found the placenta partially ossified three times in the same woman. Monro and Merriman also report several cases where they noticed ossification on the uterine surface of the placenta, in which the latter adhered a little more than usual. In a case detailed by Dr. Stoltz, the bond of union was evidently formed by a layer of coagulated blood, which had served to arrest a hemorrhage at the fourth month of gestation. Dubois accepts this view, and attributes these adhesions to patches of a whitish nature, of a greater or less degree of hardness, evidently of a fibrinous nature, and increasing in density with the age of the sanguineous effusion of which they are the only remains.

There was no history of hemorrhage or inflammation in the history of this case prior to confinement, after which she rapidly regained her former health, and soon assumed her household duties. No uterine trouble that has made itself known by an untoward symptom, has yet appeared. What the cause of the ossification and adhesion was in this case can only be theorized upon, and it remains for some future confinement to prove whether or no she will follow in the wake of Gooch's patient, and bring forth at each subsequent labor a placenta whose uterine surface is paved with stone.

## Hospital Reports.

### CASES FROM BELLEVUE HOSPITAL, NEW YORK.

Reported by J. H. Woodward, M. D.

#### Acute Lobar Pneumonia.

John A., age 42, was admitted to Bellevue Hospital February 12, 1884. Patient stated that five days prior to admission to the ward he was seized with pains in all regions of his body, and that the pain in the region of his left nipple was particularly severe. On the following day he was so sick that he could not work. He had a chill that day, and it was followed by fever. He had no appetite, and his bowels became quite loose. The pain in his left breast became more severe than before. He had a cough, and expectorated whitish matter. These symptoms became more and more marked, until he was admitted to the hospital. On admission, the patient presented the following symptoms: He was very nervous and excited, and complained of pain in his left breast, especially when he coughed or took a deep breath; he had pains in his legs, arms, and head; his face was flushed, his appetite was pretty good, his bowels were regular, the diarrhœa having ceased. Temperature 103 F.; pulse 130 and weak, but regular. Physical examination revealed rude breathing and exaggerated voice over the middle of the left scapula; sputum is thick and muco-purulent.

Treatment.—Whiskey ℥ss., and liq. morphia, U. S., ℥j, every three hours.

February 13. Patient is more quiet. His face is still flushed, and his conjunctiva are injected. Last night his temperature rose to 103¾ F; this morning it is 102¾ F.; his pulse is 100, and stronger than when the patient was admitted. He complains of pain in the axillary region on the left side low down, and has also severe pain in the head when he coughs; his appetite is good; bowels have not moved. At noon to-day his temperature rose to 104 F., and a sponge bath was ordered. One hour later his temperature was 103½ F. His pulse continues good.

*Physical Signs.*—Dullness over the lower half of the scapula and subscapular region on the left side. Bronchial voice and breathing are heard in the same regions.

Treatment the same.

February 14. In the morning the patient's temperature was 101° F.; in the afternoon it was 103¾° F. He is more restless and irritable than he was yesterday. His pulse is 96, full, regular, and strong. He complains very little of pain or dyspnœa. He coughs a great deal, and the abundant expectoration is tinged with blood. Patient is perspiring profusely. His appetite is pretty good. His bowels are confined. Bronchial voice and breathing less marked, and some rales are heard over the base of the left lung.

*Treatment.*—Whiskey, carbonate of ammonium, fluid extract of convallaria, and U. S. sol. morphiæ.

February 16. Patient has continued in about the same condition since the last note. He coughs a great deal, and expectorates muco-purulent sputa. Now he has no pain except when he takes a full inspiration. His temperature ranges between 101½° and 103° F. His pulse is 90, and full and regular and strong. Appetite continues to be pretty good. Bowels regular. Physical signs are those of resolution. Treatment the same.

February 18. Yesterday patient's temperature range was from 100½° to 101½° F. This morning it is 99° F. Pulse is 70, full, strong and regular. Eats and sleeps well. Coughs but little. The expectoration is still tinged with blood. Rales more numerous than ever before since the patient has been in the hospital. The same treatment is continued.

February 20. The improvement has been steady

until to-day. This morning the patient's temperature is 99½° F.; pulse 80, full, strong, and regular. He has more dyspnœa, and more pain in the left chest behind. Physical examination shows that the disease is resolving satisfactorily in the lower portion of the lung, but that bronchial voice and breathing have developed in the upper lobe.

*Treatment.*—Whisky, carbonate of ammonium, and morphine.

February 23. The patient's temperature is still as high as 100° F. His pulse is about 50, and is satisfactory. The patient still coughs and expectorates. He has no pain. He eats and sleeps well, and physical examination shows that the disease is resolving perfectly. Ordered whiskey ℥ss, t. i. d., and morphiæ sulph., gr. ⅛, once a day.

February 27, The patient has steadily improved since the last note. He is now allowed to go about the ward at will. He has no cough, expectoration, or pain.

Physical examination reveals a normal condition of the lung; his temperature and pulse are normal; he eats and sleeps well.

February 28. Patient discharged from the hospital cured.

**Acute Pulmonary Tuberculosis.**

Wm. C., age 42, admitted to Bellevue Hospital February 20, 1884. Patient was brought to the hospital delirious from alcohol, and was under treatment for alcoholism in the ward devoted to such patients for three days. He was then in a suitable condition to be transferred to one of the general medical wards, and that change was made accordingly. He then, being in a rational condition, stated that he had had a slight cough for six weeks, and that he expectorated more or less thick, white matter. One week prior to admission to the hospital, the patient had a chill, which was followed by an exacerbation of the cough and expectoration; and he suffered from some prostration. The patient had no dyspnœa, and he did not feel any pain in his chest, except when he coughed very hard. His appetite had failed, his bowels had been constipated, and he had suffered lately from night sweats. He had been addicted to the use of alcoholic spirits, but had not been subject to the symptoms of Bright's disease, so far as could be ascertained.

On admission to the general ward his temperature was 101½, and soon rose to 103½; his pulse was 100 and feeble; his face was flushed, and he coughed and expectorated muco-purulent matter.

Physical signs: Percussion at the right apex gives dullness. Over both sides of the chest there was rude breathing, with numerous sonorous, sibilant and moist râles. Ordered tinct. digitalis.

February 24. Temperature 101 all day. His pulse is stronger; his appetite is fairly good; bowels constipated.

February 25. The temperature range is between 101 and 102, and generally fluctuates with regularity. It is sometimes higher in the evening, and again the rise will occur in the morning. His pulse is small and feeble; he sweats at night, and feels very much prostrated; he coughs a great deal, with expectoration; he has no pain or dyspnœa; his voice is hoarse.

Physical examination: The râles heard at the former examination have nearly all disappeared, excepting at the apex of the right lung, where they are still numerous and loud. In the same region a peculiar, low-pitched respiratory murmur is heard, the exact nature of which cannot be determined.

*Treatment.*—Stimulants and medicines to relieve the cough.

March 3. Since the last note, patient has been in about the same condition. Yesterday his temperature was 102° all day, and this morning it is 103½°. His pulse is 110, small and feeble. Appetite is poor, and bowels are regular. He coughs a great deal, and has a great deal of expectoration.

The same treatment continued.

March 7. This morning his temperature is lower than usual, it being 99°. His pulse is 120 and very weak. The cough and expectoration continue, and are not relieved by anything. Since the last note patient has been failing rapidly, and now he is in a very weak condition. He vomits profusely. His tongue is dry and coated, and he complains of great thirst. He has had some dyspnœa. No decided change in the physical signs.

March 10. Patient is steadily failing. His temperature ranges between 100° and 103° every day. He is now unable to sit up in bed. He perspires profusely. Physical examination: Over the left apex in front, dullness on percussion, cavernous breathing, and moist râles; over the right apex in front, dullness on percussion, broncho-cavernous breathing, and subcrepitant râles; over the left lung behind, dullness on percussion, rude breathing, and subcrepitant râles; over the right side behind, over the apex, broncho-cavernous breathing and subcrepitant râles; over the base of the lung, rude breathing, with diminished intensity.

March 13. Patient has been steadily sinking since the last note. His temperature has oscillated in its usual manner. His pulse is very feeble. This morning he gradually became more and more stupid, and developed the symptoms of œdema of the lungs, and died.

*Autopsy.*—Lungs: fresh pleuritic adhesions over the left lung. At the apex of the lung there was a large cavity, and about it there were several smaller cavities. The remainder of the lung was quite solid, and it was studded with large numbers of small tubercles. Over the right lung there were no pleuritic adhesions. The bronchi were dilated, and one bronchus was becoming broken down into a cavity. The upper half of the lung was consolidated, and was studded with a large number of large and small grayish-white masses. The microscope confirmed the opinion that the lungs were the seat of a tuberculous deposit.

Liver: presented signs of interstitial hepatitis and fatty degeneration.

Kidneys: chronic diffuse nephritis.

The intestines were normal, excepting the ilium, which presented one small ulcer. The remaining organs did not present anything worth recording.

**Acute General Peritonitis.**

Mary K——, aged twenty-two years, admitted January 17, 1884. The patient states that eight days ago she was exposed to cold and wet while

menstruating. After that she had headache, pain in her back, and general malaise. Three days ago she had a severe chill, and was obliged to go to bed at once. The chill was followed by a febrile movement, nausea and vomiting, and severe pain in her abdomen. She also had a slight cough. Her bowels had been loose, but became constipated after the chill. During the last three days her symptoms have steadily increased in severity, *i. e.*, the abdominal pain, the nausea and vomiting, and the febrile movement had become more marked; and, when brought to the hospital, she was quite weak. The abdominal pain was most severe in the right iliac fossa.

Examination on admission to the ward revealed the following symptoms: Temperature, 102¾°; pulse, 110 and fairly good; abdomen, tympanitic and tender. Patient complained of pain in her abdomen, chiefly in the right iliac fossa. Her tongue was dry and coated. She lies on her back.

*Treatment.*—Poultices to the abdomen, to be changed every two hours. Magendie's solution of morphine as often as necessary to control the pain.

January 19. This morning her temperature is normal; her pulse 110 and fairly good. Yesterday she was given a simple enema, which moved her bowels. To-day her abdomen is as tympanitic as when she was admitted. She is very much nauseated, and feels drowsy and stupid. Her pain is less severe.

The same treatment is still continued.

January 21. Yesterday, patient's temperature sunk once as low as 98°, but it has been rising slowly since, and is 100½° this morning. Tympanites and abdominal tenderness less marked. Her bowels have moved twice during the last twenty-four hours. She vomits now and then. Her tongue is dry and coated. Pulse 99, and pretty strong. Treatment the same.

January 23. Temperature range since the last note has been between 99° and 100°. She is no longer suffering from nausea and vomiting. Her bowels have not moved since the last note. Tympanites and abdominal tenderness subsiding. She begins to show signs of liking her food. Treatment the same.

January 28. Patient has improved steadily, and nothing has occurred worthy of note. The treatment has not been changed. The quantity of morphine administered is just sufficient to control the pain. The patient has never been narcotized with the drug. To-day some unusual excitement occurred in the ward, and the patient's temperature rose promptly to 103¾. Her pulse became more rapid, and she complained of an increased amount of pain in her abdomen, and of considerable uneasinesss about her stomach.

January 29. Temperature 101° this morning. Abdomen very tympanitic. Bowels constipated. Patient is much sicker than she was on the day before yesterday.

January 31. Patient has had a pretty high temperature since the 28th inst. To-day it rose to 104°.

February 1. Temperature 98½°; pulse between 90 and 100, fairly strong and regular. She feels sick at her stomach, and vomits occasionally. Her bowels are constipated. The abdominal tenderness has diminished very much. She sleeps well.

*Treatment.*—Wine, ℥ij., every three hours; liq. morphiæ, U. S., ℥j., every three hours; and Magendie's solution, p. r. n.

February 2. Temperature rose in the evening to 104° again, and the patient was exceedingly restless, in spite of large doses of Magendie's solution. Her pulse became rapid and feeble. She vomited several times, and had more pain than at any time for a number of days. She was given a simple enema, which relieved her very much. Her bowels had not moved for five or six days.

February 3. Temperature is 99° this morning, and the patient feels much better than she did last night. Same general treatment continued.

February 5. At noon to-day her temperature was as high as 102¼°.

February 6. Temperature this morning was 98½°; pulse 72, and satisfactory. She has some pain in her abdomen still, and still lies upon her back. No vomiting. Abdominal tenderness much diminished, and tympanites not marked. Her bowels move more regularly. Treatment the same as before.

February 9. Temperature and pulse normal. Very little pain in her abdomen now, and no tenderness or tympanites. Bowels move regularly. She looks much brighter, and sleeps well. Ordered wine ℥ij three times during the day and during the night; morphine when necessary; poultices removed.

February 13. Patient is allowed to sit up in bed, and partook of a little solid food for the first time since she has been in the hospital. She does not suffer any pain now. Her bowels are inclined to be constipated, and the patient is pretty weak. Treatment the same.

February 19. For a number of days she has been out of bed, and allowed to go about the ward. Now she feels perfectly well, and is gaining in flesh and strength, and eats and sleeps well. She was discharged cured.

### Surgical Septicæmia.

Henry J., age 39 years, German, carpenter, admitted to Bellevue Hospital December 1, 1883. Patient came to the hospital with the following history: One week prior to admission he had been injured by one of his tools, and received a lacerated wound upon the anterior surface of his left forearm. This wound was dressed by a physician, and was not looked at again until the patient presented himself to me. On admission to the hospital the patient exhibited a large ulceration on the anterior surface of his forearm, which exposed the superficial layer of muscles. His hand was swollen and œdematous. About the ulcer, the surface of which was in an unhealthy condition, there was a well-marked erysipelatous blush. The patient was accordingly transferred to the erysipelas ward, where he remained one week, and was then sent back to me for further treatment, since he had recovered from erysipelas.

On his return to the ward the patient exhibited the following symptoms: His general condition was pretty good, although he was weak and anæmic. During the time he was in the erysipelas ward his temperature was normal, that is to say, it had not risen above 99° F. His left forearm was very much swollen, the palmar surface presenting a large ulcer six by three inches in size.

There were several incisions into the forearm, from which pus flowed. Through the ulcer the finger could be passed, between the planes of muscles and the individual muscles, into extensive sinuses, which were filled with sanious pus. The whole anterior of the forearm was literally riddled by extensive sinuses, which led over to the surface of the bones. The bones were not bare at any point, however. The dorsum of the hand was very œdematous, and at a number of points fluctuation was detected.

Incisions were made into the hand at various points, and a considerable quantity of unhealthy pus evacuated. An aqueous solution of corrosive sublimate, of the strength $\frac{1}{2000}$, was forced into every portion of this extensive region of disease. And the forearm and hand were enveloped in a dressing composed of carbolized gauze, wet in $\frac{1}{40}$ carbolic solution, placed next to the wound, and over all borated cotton.

Patient's temperature rose to 110° F. that evening, and remained high for two or three days. During this time he developed the following symptoms: He became very apathetic; his skin and tongue became dry; his pulse was rapid and feeble; his bowels were constipated; his temperature was at least 100° F., and he had no appetite. His arm was carefully dressed with every attention to antiseptic precautions at least once a day. Drainage was secured perfectly by the introduction of about one dozen rubber tubes into the various sinuses and pus cavities. These tubes were introduced as early as the third dressing of the case. The affected district was constantly irrigated with the corrosive sublimate solution at every dressing. Every part where pus might lodge was carefully irrigated again and again with the mercury solution. And the carbolized gauze was wet in the same solution, and applied wet, after the third dressing. Iodoform was not used for fear of poisoning by it. The forearm and hand were elevated and steadied by a dorsal splint.

This was a case in which constant irrigation of the wound should have been the first choice in the treatment. That plan was seriously considered, but obstacles were in the way of its employment, and it was rejected.

Under this treatment the patient improved until December 18, when after having remained steadily for a number of days at the normal point, his temperature rose to 103° F., and continued high for twenty-four hours. The dressings were changed twice on that day, and the patient's temperature remained as high as 100° F. The strength of the corrosive solution used was doubled. His general condition was not satisfactory. He was very apathetic still, and his tongue was dry and cracked, and his teeth were covered with sordes. His skin was dry and his bowels constipated. His right eye presented a corneal ulcer. Large quantities of sanious pus still flowed from his forearm. The patient's condition was so desperate, and the task of disinfecting the source of his septicæmia was so great and hazardous, that the question of amputation was considered. But it was decided that the patient was so weak that he might perish from the shock of the operation, and that his best chance lay in continuing the treatment already adopted.

Within forty-eight hours after beginning the use of the stronger solution of corrosive sublimate, the patient's temperature fell to normal, and did not rise above 99 again. For about a week the case was dressed twice a day, and thoroughly disinfected with the $\frac{1}{1000}$ solution. After that the dressings were only changed once daily. Patient's general condition improved slowly, but steadily, while the condition of his forearm improved. The purulent discharge from the patient's wounds became smaller in amount and more healthy in character.

January 1. Patient has improved so much that it is not necessary to dress his wounds every day, and the $\frac{1}{2000}$ solution of corrosive sublimate is used instead of the stronger solution. The sinuses and ulcer in the forearm are granulating satisfactorily, and only a small number of drainage-tubes are necessary now. He is much brighter and stronger.

January 12. He was allowed to sit up.

February 1. Discharged, to return as an office case. The sinuses have filled up, and a superficial ulcer only remains of all the extensive granulating surface. The patient returned to the hospital several times to have his arm dressed, but, unfortunately, ceased to come before he should have done so. At his last visit his forearm presented a small, perfectly healthy ulcer. The wrist-joint and the phalangeal joints were in a state of false anchylosis, which yielded readily to passive motion. The patient's hand and forearm might have regained their power and usefulness in a short time, I have no donbt, had passive motion, frictions, and douches been carefully and steadily employed.

In addition to the vigorous antiseptic management of the wound, powerful stimulation with whiskey, wine, and digitalis, was necessary. Iron and small tonic doses of quinine were given day and night, together with the stimulants, and the patient was urged to drink plenty of milk. His bowels were kept open with laxatives. During the most serious period of his illness, the patient received several sponge baths, the temperature of the water used being as high as 104, at least. These baths were given in order to improve the condition of the skin, which was very dry, and did not perform its function properly. They apparently benefited the patient.

In this case there are many square inches of raw surface which was not covered by granulation tissue for a certain time, and which was covered by that tissue later. Upon this surface, every day, for a considerable period, quarts of the aqueous solutions of corrosive sublimate were poured. The bichloride was kept constantly applied to the large ulcer on the forearm, for the gauze used was saturated with the mercury solution. And yet the patient did not at any time show the first symptom of mercurial poisoning. Had strong solutions of carbolic acid been used, instead of the bichloride, there then can be little doubt that we should have had a case of poisoning by that acid.

### Rupture of Intestine.

John O'R., age 17, driver, was admitted to Bellevue Hospital in October, 1883. He came to the hospital with the history of having been run over by a truck, the wheels of which passed over the

middle of his abdomen. He was thrown into considerable shock by the accident, but rallied sufficiently to walk to the ambulance, a distance of two or three rods. He did not complain of much pain, and wished to go home, after he had reached the hospital. On the following morning he was transferred to Bellevue. When he reached the ward his pulse was weak. He was not in much pain, and conversed rationally. His abdomen was tender, but not tympanitic, and it did not present any signs of injury, beyond the tenderness. The patient was in shock, although he appeared to be in very good condition. His temperature was normal. Two hours after admission the patient died.

*Autopsy* twenty-four hours later. Abdomen very tympanitic. The right side of the scrotum is very large, and suggested the existence of a hernia. The usual incision in the median line was made, and gas was found in the peritoneal cavity. There were the usual signs of acute general peritonitis, and the omentum was very much contused. There was no hernial protrusion at any point. But the enlargement of the right side of the scrotum was due to the presence of gas in the sac of the tunica vaginalis. The right inguinal canal was not unusually patent. Beneath the visceral layer of the peritoneum there was gas, which had forced its way to this situation from a vent in the duodenum. This gas, beneath the peritoneum, exhibited a very striking phenomenon. The appendices epiploicæ were inflated with the gas, and looked like a large number of shining glass bulbs suspended from the transverse colon.

Fæcal matter had been extravasated into the peritoneal cavity through the rent in the small intestine. The right kidney was ruptured in several places, and the rupture went through the cortical substance. There was bloody urine in the sinuses of this kidney, but no blood had been noticed in the urine before death. The remaining organs of the body were in good condition.

The observation of the presence of gas in the sac of the tunica vaginalis in this case of ruptured intestine proves that such a thing may occur, even when the inguinal canal is normal. And the fact may become a significant one in some case in the future. For, omitting other signs of rupture of the intestine, the presence of gas in the sac of the tunica vaginalis, in cases where no local cause for it exists, would, in cases where the abdomen was tympanitic, be pathognomonic of rupture or perforation of the intestine. The determination of the existence or absence of a lesion of the intestine when it is suspected, becomes a very important matter, both for the proper prognosis and for the proper treatment of the case.

# Medical Societies.

## NEW YORK NEUROLOGICAL SOCIETY.

(*Concluded from page* 526.)

### DISCUSSION.

Dr. J. C. Shaw: "I have been called three times in consultation in these cases where atropine was used; there was a great deal of pain, and marked neuropathic tendency; insanity in the family in one case. There is one difficulty in the treatment by atropine—that it sometimes causes disagreeable symptoms, especially in delicate women. In one case, where the drug was pushed, it caused such distress that the patient, a woman, refused to take it longer. Atropine in large doses cannot be used in all cases therefore."

Dr. C. L. Dana said, "that Dr. Leszynsky was entitled to great credit in employing atropia against such physiological odds. He believed that the cure was due to the employment of atropia. One point must be borne in mind, and that is that we must select our cases. In those cases where the disease is plainly neurosis, atropine may answer. In many cases, however, the disease appears to be of a peripheral and rheumatic character. Here anti-rheumatic remedies answer better."

Dr. Gibney: "In view of the fact that Dr. Leszynsky administered electricity and other agents, as his report shows, some doubt might be expressed as to the curative effects of the atropine injections. The relationship of cause and effect does not seem sharply enough defined. I have had no personal experience with this drug in torticollis. A few years ago, in a case of rotary spasm of the head, I had a very prompt and excellent result in the use of the fluid extract of gelseminum carried to tonic doses. Dr. Leszynsky certainly deserves credit for the heroic dosage of atropine in this case."

Dr. Birdsall related the history of a case of torticollis treated at the Manhattan Hospital by his assistant, Dr. Perriberry, in a child about eight years of age, by the application of as strong a galvanic current as could be endured for from twenty to thirty minutes, on the affected muscles, three times a week, for several weeks, with gradual improvement, which finally terminated in complete recovery. Tincture of belladonna was administered in drop doses, until slight physiological effects were produced. Dr. Birdsall was inclined to credit the curative effect in this case mainly to the galvanism, though he thought that a combination of the method with atropia and that of galvanism, would in general be far more serviceable than either alone.

Dr. Weber: "Was a traumatic effect produced by the hypodermic injections?"

Dr. Leszynsky: "The injections were made into the substance of the muscle, and no traumatic effect was produced. The preparation of atropia used was Morck's, and the solution was freshly prepared every two or three days."

Remarks of Dr. David Webster:

"*Mr. President:* I have listened to Dr. Leszynsky's paper with much interest. Although I have seen but few cases of wry neck, I have had a good deal of experience with atropine, and I beg leave to question whether the same results might not have been accomplished by smaller doses applied locally. For the purpose of relaxing the sphincter pupillæ and the ciliary muscle, we never give atropia by the mouth or hypodermically, but always apply it locally—to the surface of the eyeball. Less than one twenty-thousandth of a grain applied to the conjunctiva will paralyze the muscles I have named, while it would require a many

times larger dose to produce the same effect if given hypodermically.

"It is remarkable that Dr. Leszynsky's patient tolerated so large a dose as one-sixth of a grain. There is a wide difference in the quantity required to produce the physiological effects of the drug in different persons. I have frequently seen a drop of a four-grain solution, applied to the eye, produce the peculiar scarlet flushing of the face, especially in infants. I also know of a case in which a single drop in the eye caused marked delirium in a young lady, so that she had to be taken home in a carriage. I have had some personal experience with the physiological effects of atropia. I once swallowed what I supposed to be ten drops of Magendie's solution of morphia, to check a diarrhœa while I went to Brooklyn to assist in an enucleation. On the way, I noticed that I felt very strangely, going off into curious dreams, entering into imaginary conversations, etc. When I got to the place of operation, I found on attempting to talk that I could scarcely speak above a whisper, my mouth and throat were so dry. Dr. Agnew noticed that my face was flushed and my pupils dilated. I went home and went to bed, and slept soundly until the next morning. As soon as I awoke, it dawned upon me that I must have taken atropine instead of morphine. As soon as I saw Dr. Agnew, he told me he had arrived at the same conclusion. I found the atropine and morphine bottles side by side on my table. The mystery was explained.

"I once saw a case in the practice of a brother practitioner where one-sixteenth of a grain of sulphate of atropia given with half a grain of morphia subcutaneously produced delirium, lasting for half a day or more. This was in a hysterical lady who was used to hypodermics of morphia without atropia.

"Dr. Leszynsky's method of giving the drug was a perfectly safe one, however, as he cautiously felt his way from smaller to larger doses."

Dr. G. W. Jacoby said: "It was not my intention to make any remarks upon this subject, as the objection which I intended to raise to the indiscriminate employment of galvanism and atropine in the treatment of Dr. L.'s case, has already been made by some of the preceding speakers; but Dr. Gibney's remarks in reference to the facility of producing the physiological effects of atropine, in some cases, by very minute doses, recalls to my mind very vividly a case in which this was also very noticeable. The patient, a girl, aged twelve years, came to me affected with a left-sided tonic torticollis, probably of rheumatic origin. My results with electricity upon other cases having been unsatisfactory, I determined to treat this case by the hypodermic injection of sulphate of atropia. I therefore injected $\frac{1}{30}$ of a grain of the drug.

"This one injection produced all the symptoms of atropine poisoning, ending in a violent delirium, which lasted for ten hours.

"When the patient had recovered from the effects of the atropine, I naturally felt reluctant to continue its use, and began treatment of the torticollis by galvanism. After two weeks the child was discharged from treatment entirely recovered.

"The points which I wish to mark are, firstly, the small amount of atropine necessary in this case to produce delirium; and secondly, the fact of a cure by self-limitation, or possibly through the action of the galvanic current. Had no ill effects resulted from the use of the atropia, I would probably have continued its use, and my patient recovering, it would have been only natural to attribute this recovery to the use of the atropine.

"Therefore, we cannot be too cautious in drawing our conclusions from a single case, no matter how well observed; and we should be very careful not to use two potent remedies, such as galvanism and atropine, simultaneously, as our skepticism in regard to the efficiency of either one will not be considered scientific proof of the beneficial action of the other."

Dr. Leszynsky, in closing the discussion, said: "As Dr. Dana saw the patient referred to in my paper, I am pleased to hear that he agrees with me in stating that recovery was due to the employment of the atropia.

"In reporting the history of this case, I expected that the question would arise as to which of the remedies employed had effected the cure, therefore I was not surprised to hear the criticism of Drs. Gibney and Jacoby; and in reply I will state that the number of cells used in applying the galvanic current was from ten to twenty of a Stohrer portable battery. The patient could not tolerate a stronger application, and this was continued for nearly fifteen minutes daily. After the removal of the electrodes, I found that the spasm invariably became more vigorous than ever, and I always allowed about ten minutes to elapse before injecting the atropia.

"I would again direct the attention of the society to the fact that notwithstanding the daily application of galvanism in conjunction with the use of atropia, *no improvement was shown until the twentieth day, soon after a rapid increase of the atropia from gr.* $\frac{1}{10}$ *to nearly gr.* $\frac{1}{8}$. Then the improvement became so evident that it can hardly be doubted that the atropia was the important element which effected the successful result. In regard to the use of the bromide of sodium, I can safely say that bromism was not produced. The faucial reflex was frequently tested, and remained well-marked throughout the entire course of treatment.

"Dr. Webster's suggestion may be a very good one if we accept it from an ophthalmological standpoint, but in this class of cases I cannot see what advantage could be gained by the inunction of the oleate of atropia.

"The object in using this sulphate of atropia was to produce paralysis of the trunk and branches of the spinal accessory nerve, therefore it was injected into the substance of the muscle for the purpose of producing its *local effects* on the motor nerve, although eminent authorities like Ringer and Traser have concluded, after an elaborate series of experiments upon living animals, that atropia paralyzes the motor nerves through its action upon the spinal cord, and not by the action through the circulation. I believe that the oleate if applied locally would produce more rapid constitutional symptoms on account of its speedy absorption; and another objection is that the dose cannot be so accurately determined.

"In conclusion, I will state that the patient remains well, and that no sign nor symptom of spasm has since been shown."

NOMINATION OF OFFICERS FOR ENSUING YEAR.

President—Birdsall, Gray, Morton, W. A. Hammond.

First Vice-President—C. L. Dana.

Second Vice-President—G. W. Jacoby.

Recording Secretary—E. C. Wendt.

Corresponding Secretary—W. M. Leszynsky.

Treasurer—E. C. Harwood.

Councillors (five)—Weber, Seguin, Jacoby, Morton, W. A. Hammond, McBride.

The society then adjourned.

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## PHILADELPHIA COUNTY MEDICAL SOCIETY.

### Discussion on the Treatment of Chancroid and Syphilis. (*See p.* 545.)

Dr. J. William White opened the discussion by saying that there were a few points as to which he differed from Dr. Ashhurst, and to which he would take the liberty of alluding. The treatment of chancroid as proposed by Dr. Ashhurst, had some distinct disadvantages; in the first place it is very painful, and as a matter of fact it is not practicable to etherize one's office-patients, for the purpose of cauterizing chancroids. In the next place, cauterization increases the liability to suppurating bubo. Cases of the latter complication had been much rarer in his practice since he had stopped the indiscriminate cauterization of chancroids, and, in fact, for several years past he had seen them in hospitals, where the cases have been cauterized before admission. Another strong objection to cauterization is that it is extremely apt to produce phymosis, and thus convert an exposed sore into a concealed one much more difficult to treat. If the prepuce were retracted and left so after cauterization of the sore, as recommended in some cases by the lecturer, paraphymosis, an even more annoying complication, would almost certainly result. Then, too, the diagnosis of the sore is rendered more difficult by the cauterization. He did not believe chancroid to be a specific sore in the sense that it is due to a special poison, producing only this form of ulceration, but thought it was due to pus-contagion, owing all its distinctive peculiarities, if it could be said to have any, to the anatomical and histological peculiarities of the parts involved; he was convinced that his cases got well more rapidly when cauterization was omitted than when it was employed. As to cases which *should* be cauterized, they included in his practice only those sluggish sores which refused to take on reparative action under milder stimulus, and those phagedænic sores which are accompanied by rapid and dangerous breaking down of tissue. When a cauterant is necessary, fuming nitric acid was, in his judgment, the one to be preferred. The majority of cases do not require cauterization, and he thought could be best treated by observing the local indications; if the ulcer is inclined to be sluggish, a ten-grain solution of sulphate or acetate of zinc, or a six-grain solution of sulphate of copper, or a thirty to sixty-grain solution of nitrate of silver, will often cause it to take on healthy action; if the ulcer is red with exuberant granulations, or surrounded by an inflamed area, then lead-water and laudanum would be indicated, or a weak solution of zinc in laudanum and rose-water. Iodoform will often effect a cure more certainly and rapidly than any other remedy, but the objection to it is the penetrating odor so offensive to many persons. He had tried all sorts of perfumes and pharmaceutical disguises without effect, and had finally adopted the plan of advising his patients to tie up a finger with some of the ointment, thus diverting suspicion from the true cause of its employment.

His experience in the Philadelphia Hospital had left him convinced that in the treatment of phagedænic and serpiginous ulcerations, bromine was the best local application; fuming bromine should be applied freely, not only to the surface of the ulcer, but also to all its interstices; it is afterwards covered by oiled lint. He had tried the so-called "horse-shoe" method of counter-irritation in bubo without much benefit, and favored pressure with a shot-bag or half brick covered with flannel.

As to the suppurating bubo, he agreed with Dr. Ashhurst as to the mode in which the incision should be made in opening it, but said that curiously enough it was for a directly opposite reason. He made the incision parallel with the long axis of the body, so that the lips of the wound would *not* gape. When the incision was made parallel with Poupart's ligament, whenever the thigh was extended on the body, the attachment of the fascia lata to the lower lip or wall of the suppurating cavity, and the attachments of the abdominal muscles and fascia to the upper wall, resulted in a wide separation of the wound, making a larger cavity to fill up with granulations, and thereby delaying complete recovery very considerably.

In the treatment of sub-preputial chancroids he would hesitate, for the reasons stated, to retract the prepuce and cauterize, even if it were possible to do so, which would rarely be the case; he considered the paraphymosis, which would almost invariably result, a very objectionable complication; as to packing the space between the glans penis and the foreskin with lint, he believed it in the great majority of cases to be practically impossible, without exciting a degree of pain, inflammation, and hemorrhage, highly prejudicial to the patient: a certain amount of lint might be stuffed in, but he doubted that it could do anything but harm. In his cases of concealed chancroid—or of balanitic or herpetic ulceration with phymosis—he said he directed patients to clean the parts every two hours, injecting with a Taylor's subpreputial syringe, warm water and castile soap; then to wash away all the soap with plain warm water, and then finally to inject a solution of zinc in laudanum and rose-water, five to ten grains of zinc to the ounce of the mixture.

The local treatment of the infecting sore or true chancre was chiefly interesting in regard to the question of excision. If it were believed that the chancre was the first symptom of constitutional syphilis, it would, of course, be illogical to remove the sore with any idea of preventing systemic infection; but if, on the other hand, it were thought that the poison of syphilis, whatever it might be, found its way into the blood, and into the tissues from a point of original inoculation—the chancre—through the medium chiefly of the lymphatics—then it would be entirely philosophical to excise the sore in the hope of preventing constitu-

tional disease. This was the view which he was inclined to favor.

The argument that in the *majority* of cases excision of the sore fails to prevent general disease, does not in the least affect this view of the matter. It is to be expected that in most instances a portion of the *materies morbi* would have passed beyond the reach of the knife before producing sufficient local symptoms to attract attention. Consequently the majority of cases fail, and always will fail. The possible errors due to mistaken diagnosis, or to the *post hoc ergo propter hoc* method of reasoning, were, of course, familiar to all syphilographers; but it seemed manifestly unfair to include all the reported cases of successful excision of chancre under those heads. The only ways in which the true character of a hard chancre can be determined prior to the occurrence of constitutional infection, are by its microscopical peculiarities and by "confrontation," or inspection of the person from whom it was obtained. Such cases must of necessity be very rare. He had been fortunate enough to have seen two of them—in both of which the sores, which were situated on the prepuce, had been excised and no constitutional syphilis had followed. They were obtained from women with marked secondary syphilis, and were examined microscopically by Dr. Simes, who found them to possess all the peculiarities of Hunterian chancres. Even two such cases, he thought, ought to be given great weight in a fair consideration of the question.

When, however, the sores are not seen at a very early stage of their development, or when they are situated on the glans penis so that their removal will cause deformity, or will give rise to much pain or hemorrhage, he thought the chances of preventing constitutional disease not sufficient to warrant the operation.

As regards the important question of the proper time for beginning constitutional treatment, Dr. Ashhurst's opinion did not seem to him to be consistent with the received facts of syphilography. It was an undisputed axiom that there is no absolute proof of the infecting nature of any given sore except infection itself, as manifested by certain constitutional symptoms. Mercury indefinitely delays or altogether prevents those symptoms, and its administration at the time recommended by Dr. Ashhurst would leave both patient and surgeon in doubt for all time as to the presence or absence of syphilitic taint. As the proper treatment of syphilis involves a prolonged course of mercury, and the surgeon is compelled to insist upon abstinence from matrimony, or, if the patient is already married, the avoidance of conception, the responsibility is very great, and therefore nothing but entire certainty would justify the beginning of treatment. Where confrontation aids the diagnosis, it might, perhaps, be allowable to begin sooner—but, although doubtless it is desirable to give mercury as early as possible, it has been abundantly shown that no great harm results from delaying its administration until the roseola or at least the general glandular involvement has established the fact of syphilitic infection.

After alluding to the various theories for using mercury, he said his own plan was to give it by the mouth, in the form of the protiodide. He gave four pills a day for two days; then six pills for two days; then eight pills for the same period, and so on, until the patient's gums or his posterior molars became a little sensitive, or his saliva thickened and became more profuse; then the dose was usually divided by two, or if the toxic effect had been produced by a daily dose of only six pills, the subsequent or permanent dose (the so-called "tonic" or physiological dose) was reduced to two-thirds of that, or four pills. He thus determined in each case the quantity of mercury required to affect the new formations of syphilis, as it is well known that embryonic cells or tissues have less resistent power to either therapeutic or pathological forces than the normal cells. This dose was then continued, subject to increase in case of an attack of new symptoms, for a period of eighteen months to two years. Afterwards, he said, he put the patient on the mixed treatment of biniodide of mercury and iodide of potassium for six months. He then stopped and kept him under observation, returning to the mixed treatment if any new symptom appeared, and continuing it for several months.

Going over his case-books for the past seven years, rigorously excluding all hospital and dispensary cases, and all cases which had not been under his care and observation continuously from the primary sore down to the present time, he still had notes of one hundred and seventeen cases with whose personal and family history he was entirely familiar. These cases had all been treated upon this plan. Excluding the minor manifestations of syphilis, such as trifling mucous patches, occasional papular or squamous patches, etc., he found that among these persons there had occurred the following accidents which were fairly attributable to syphilis: four miscarriages, three of which were certainly due to syphilis, and one of which was doubtful; one case of perforation of the hard palate; one of epileptiform convulsions, and two of iritis; in one case the patient lost his penis from phagadænic ulceration supervening in a hard sore at the time of the secondary outbreak, but as he had gone on a long journey and neglected all treatment, this should not properly be set down in the list; not one of all the others had an eruption which betrayed him to his family or friends, and the great majority did not lose a day from their various occupations of business, pleasure, or professional work. In conclusion he said, that having had such results by the continuous plan of treatment, he had not thought it necessary to make any extended trial of the intermittent plan, and consequently could not speak from any large experience with it; nor did he think that, without further evidence upon the subject than he had yet heard, he would modify his present plan of treatment, though the intermittent plan had some distinguished advocates.

Dr. S. W. Gross thought that too much material had been presented for discussion, as there was enough to occupy four or five evenings; he would, therefore, limit his remarks to one or two points. In regard to the treatment of chancroid, he said he would have made about the same remarks as Dr. Ashhurst. He was in the habit of destroying the ulcer, with the triple object of preventing its increase, of preventing the auto-inoculability of the discharge, or the formation of

other sores in the immediate neighborhood of the primary lesion, and preventing the formation of a bubo. His practice was to touch the sore with pure carbolic acid for its anæsthetic effects, and follow this with nitric acid. A dry dressing, in the form of absorbent cotton or picked lint, was then applied, and continued after the slough had come away if the resulting sore was not large; otherwise he employed a mildly astringent wet dressing, say three drops of nitric acid to the ounce of thin mucilage, or two grains of tannin and one-eighth of a grain of sulphate of copper to the ounce of water, or three grains of chloral to the ounce, if the surface be sensitive.

With regard to iodoform, on which the preceding speakers placed great reliance, he had only to say that he had no faith whatever in its action. The device of Dr. White of wearing an iodoform rag on the finger is so well known in this city, that it deceives no one. In his wards at the Philadelphia Hospital, during his connection with that institution, he had invariably found that iodoform dressings retarded the process of cicatrization in simple as well as specific ulcers, the granulations being rarely larger than pin-points. For this reason, with a view to induce a healthy granulating process, he had treated all such ulcers, left by his predecessor, with the nitric acid lotion, with the best results. His own empirical observations in this direction are sustained by some histological peculiarities pointed out by a German experimenter, whose name had escaped him, in a recent number of *Virchow's Archiv*. The writer shows that iodoform prevents the formation of polynucleated epithelioid cells and giant cells in granulations, and in this way accounts for the good effects of the remedy in scrofulous and tubercular granulations. From these experiments we may fairly infer that the formation of the elements essential to the rapid repairs of other granulating surfaces is prevented by the use of iodoform.

In reference to the treatment of syphilis, he agreed with Dr. Ashhurst that it should be by mercury, but he did not employ the remedy in the primary stage, because he wished to know what course each case was going to take. If the advent of the symptoms was masked or retarded, no one could tell from a prognostic standpoint what might occur afterwards. It not unfrequently happens that a man says he was treated with mercury for the initial lesion some months before, that no general symptoms have developed, and asks whether he can marry. In such a case as this the treatment has delayed the appearance of the general symptoms, and the question can only be answered after several months of observation without any treatment whatever. For these reasons he withheld mercury in the primary stage. Before the appearance of general symptoms, he employed the blue pill where the protiodide did not agree. He was also in the habit, he said, of giving opium and tartar emetic to keep up the action of the skin, as the poison should, as far as possible, be eliminated in that way. He gave $\frac{1}{4}$ gr. of opium; $\frac{1}{20}$ gr. tart. emetic, and $\frac{1}{2}$ gr. of protiodide, or $1\frac{1}{2}$ gr. of blue mass, the dose being gradually increased until the tolerance of the patient was established. He thought that the mercurial treatment should be continued for months and months, with an occasional intermission, in accordance with the rules established by Keyes and other syphilographers.

Dr. John V. Shoemaker said that the use of mercury by the mouth, as recommended by the speaker, would not answer in all cases. In some the alimentary canal will not tolerate the drug; particularly is it the case in debilitated and broken-down persons, who seek treatment in the various dispensaries and hospitals. In others, the mercury at times fails to make any impression, and in such instances, it often passes out of the body by the secretions. He recalled a case of secondary syphilis, in which he administered for several months, first the protiodide, and afterwards the corrosive chloride of mercury, both in small and large doses, without obtaining the least impression either from the drug or upon the lesions on the skin. In this instance he began later to treat the patient by the use of the corrosive chloride of mercury hypodermically, injecting one-tenth of a grain of the corrosive chloride of mercury, dissolved in water, deep into the subcutaneous-cellular tissue, and a cure followed within a few weeks. For the past three or four years he has followed, to a large extent, this plan of treatment with good results, and has never had any unpleasant symptoms follow mercury used in this way. If the needle is in a good condition, a gold one being preferable, and the operator inserts it deep into the cellular tissue, either in the superior or inferior scapular or sacral regions, abscesses will not follow. Dr. Shoemaker then illustrated, upon a patient having secondary syphilis, whom he had brought before the Society from the Philadelphia Hospital for Skin Diseases, the treatment of syphilis by the use of the corrosive chloride of mercury hypodermically. The eczematous condition of the skin, that sometimes follows the inunction method of treatment referred to by Dr. Ashhurst, can very often be avoided, by using, before the inunction of the mercury, a hot-air or steam bath. In treating patients in this manner at the Philadelphia Hospital for Skin Diseases, he always preceded the inunction with either one or the other form of a bath alluded to, and has caused the ointment to be better absorbed, and thus prevented the irritation to the skin. In the treatment of chancroid, he has used the oleate of zinc, dusted over the surface, with most decidedly good impression upon the parts. It has the quality of being odoriess, and has a slight stimulating, as well as an astringent action.

(*To be Continued.*)

### The Origin of the Word "Charlatan."

The *Æsculupian* says:

It is generally admitted that the word "charlartan" is derived from the Italian word *Ciarlare*, to chatter, to prate. It appears that up to the sixteenth and seventeenth centuries the word was pronounced "chiarlatan." A German journal gives its etymology differently: a Paris physician, Latan, went through the town in a chariot containing his drugs, and in which he examined his patients. This caused the expression "Voila le Char de Latan," which was subsequently corrupted into "charlatan."

# EDITORIAL DEPARTMENT.

## PERISCOPE.

**Perineal and Penile Fistulæ: Scrotal Bisection.**

In the *Brit. Med. Jour.*, February 23, 1884, Mr. Richard Davy says:

During the last year, I have operated on two most severe and obstinate instances of penile and perineal fistulæ; the results gained have been so satisfactory as to warrant me in directing your special attention to the surgical treatment of these miserable affections. I propose (1) to consider the subject of traumatic stricture of the urethra; (2) to briefly narrate the clinical facts; and (3) to offer some suggestions with regard to the operative treatment.

A man receives a severe blow on his perineum; hæmaturia or retention of urine follows; the acute symptoms subside; but the injury mechanically stamps that urethra with the origination of stricture; and slowly, but surely, the calibre of the urethra diminishes. The osseous arch of the pubes, and the tense, unyielding triangular ligament, favor the intensity of the blow by affording counter-resistance; and this is exemplified in some accidents by well-marked comminuted fracture of the subpubic arch, associated with rupture of the membranous portion of the urethra. Let me pass over the tedious interval (it may be months or years) between the date of the accident and the formation of the traumatic stricture, and state merely that this interval represents the period of its growth; the man complains of increasing difficulty of micturition, straining, incontinence, and loss of energy, during the time that his urethra is becoming smaller at the point, and larger on the vesical side of the stricture; his bladder is becoming generally hypertrophied; and his kidneys hyperæmic; in consequence of the ponding back of the urinary excretion. By reason of a persistent strain on an originally bruised urethra, the mucous membrane gives way, and nature relieves herself by establishing one or more fistulous tracks; these are the result of urine leaking through the damaged pipe, and setting up irritation in the perineal and penile districts, gradually showing this infiltration by great general uneasiness and concomitant abscesses. So soon, however, as the skin breaks, the urine gushes through, and the banks of the sinus become gristly and indurated; thus fortifying the adjacent structures from further extravasation.

But, at this stage, pray consider the man's misery; his bed-linen wet by night, his shirt and trousers by day; his groin, thighs and buttocks chafed; his never-ceasing consciousness of not being as other men are; his own smell, and that of his garments, nauseous to himself and repulsive to his neighbors! Would not any one of us feel life intolerable under these hard conditions? and would we not risk everything, and submit to anything that held out reasonable and welcome hope to such distress of mind and body? These patients have done so; and I will now, secondly, give you their short clinical histories.

Case 1. *Penile and Perineal Fistulæ: Traumatic Stricture of Urethra: External Urethrotomy and Bisection of the Scrotum: Recovery.*—J. O., aged 44, blacksmith, residing in Cornwall, married, was admitted into Mark ward, under my care, on October 19, 1882. He had been a healthy, strong man. In 1870, when shoeing a colt, he was kicked in the scrotum and perineum. Two weeks afterwards, he felt pain and urethral discomfort in micturition, and he noticed that his stream was diminishing in volume, and his propulsive power lessening; the act being accompanied by much straining, and occupying more and more of his time. These symptoms went on until 1879; when, after intense pain, two fistulæ opened anteriorly and posteriorly to his scrotum; the perineal fistula came first, and carried fully one-half of his urine. The penile fistula dribbled; and the natural channel conveyed about one-half *per meatus*. He was the subject of a right inguinal hernia, and had a patent left abdominal ring; both groins suffered severely from the straining, but the hernia was not originally caused by it. No instrument could be passed *per urethram*. His condition was desperate; and he was sent to London, as a last resource, on the recommendation of his clergyman. On October 24, 1882, the man was placed under the influence of chloroform. A grooved director (almost straight) was passed down the urethra to the face of the stricture at the membranous part, and the knife was directed from the penile fistula, along the median line of the whole of the scrotum, until the director emerged at the perineal wound; the stricture was recognized and cut across, and a sound passed into the bladder from the perineum. On withdrawing the director from the meatus, a No. 12 retentive catheter was passed from the meatus out at the perineum, and again from the perineum into the bladder, so as to ensure that the newly-opened line was the channel occupied by the elastic instrument. This elastic instrument, or one like it, was retained in the bladder for nearly four weeks at a time, until January 9, 1883, when the patient was quite well; all fistulæ closed, no scrotal pain nor discomfort. No. 12 sound was passed along the whole urethral tube. He had perfect control of urine by day and night.

On January 16, 1883, he left Westminster to pursue his business in Cornwall as a blacksmith.

Case 2. *Stricture of Urethra: Traumatic; Scrotal Fistula and Infiltration: Bisection of the Scrotum and External Urethrotomy; Recovery.*—John L., aged 38, married, a chairmaker, was admitted into Mark Ward, under my care, on August 22, 1883. In 1868, he fell off a rick which he was thatching, and injured his perineum by falling on some wood. He did not pay any particular attention to the accident, and thought it would pass off; but, for the last six years, he had found much straining and inconvenience during micturition; and, in the early part of July, 1883, an abscess formed by his right erector penis muscle and scrotum, and was opened by Mr. Turner, of High Wycombe. Mr. Hayden also saw him, and performed suprapubic puncture of the bladder, and caused his urine to pass through a catheter for a fortnight by

the suprapubic aperture. As the urine persisted in traversing the scrotal fistula, he was sent to the Westminster Hospital. On August 27, I bisected the whole scrotum, and laid the stricture open freely, but with much care; passed No. 10 red elastic catheter from the meatus into the bladder, and retained it *in situ* for a fortnight. The fistula entirely closed, and the wound healed most kindly; he left the hospital on October 4, 1883, and passed the whole of the urine freely through its natural channel.

On October 27, 1883, I again saw the patient, and, in every respect, he was sound and quite well.

Let me now offer some practical observations on the subject of operative treatment in these loathsome cases. The first object of the surgeon must be to restore to its normal calibre the channel of the urethra, and maintain such dilatation. In some cases, notably those under the care of Mr. Barnard Holt, such dilatation of the stricture has sufficed also for the cure of the fistulæ. When I acted as Surgical Registrar to this hospital, I had many opportunities of seeing fistulæ close, on the the renovation of the urethra by immediate dilatation. In the event of the fistulæ remaining intractable and patent (excluding the operation of perineal section or external urethrotomy), the best course to pursue is to divert the stream of urine temporarily from the fistulous track (*vide Surgical Lectures*, subject viii., pages 58 and 59, "On Puncture of the Bladder *per Rectum*"), either by suprapubic aspiration, or by puncture *per rectum*, or by opening the urethra somewhere on the vesical side of the stricture. I have tried them all, and have even taken pains to pump out the urine from the bladder for two or three days at a time, and to forbid any urine to be retained in the bladder, or to be expelled by involuntary spasm or change of posture. Some mechanical operation with this intention does certainly aid the chance of union, either with or without a plastic operation. Some of my cases have been very successful, others most annoying failures; and, had I my choice of only one operation for this class of cases, I should, from experience, choose "perineal section," and I will now lay before you my reasons for this preference.

1. The signal benefits gained from perineal and scrotal section in these these two cases of stricture and fistulæ, respectively of twelve and fifteen years' duration from date of accident.

2. The reflections induced by watching how well and satisfactorily the wound for lithotomy unites in moderately healthy subjects, although no special means beyond care and cleanliness are adopted.

3. The free drainage granted right and left to the swampy tissues involved, and the marked softening and improvement of the gristly channels of urine. Moreover, by this simple but efficient free outlet, the maximum amount of rest is given to the divided stricture during micturition.

4. The total absence of interference on the part of the surgeon during recovery, thereby economizing mental and physical suffering on the side of the patient.

5. No important structures are divided, so far as the scrotum is concerned, by strictly keeping in the middle line (*vide Lancet*, May 20, 1882, Mr. Gould's case of Amputation of the Penis).

By this scrotal extension of the perineal section, originated by that grand surgeon, Syme, there are some cases, hitherto refractory, to be cured by our art. The operator challenges, in one continuous line, his patient's stubborn foes; and, by concentrated action, cuts his way through them all (fistulæ, sinuses, swamp, gristle, and stricture); and, quoting a parody which has been applied truthfully to allied conduct, he puts all his little troubles into one big one.

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**An Attempt at Suicide by Cardiac Transfixion.**

The following case is recorded in the *Edinburgh Med. Jour.*, March, 1884:

The patient, C. S., was an elderly lady, in confinement in an asylum on account of her suicidal proclivities. For many years she had suffered intense and almost constant agony from neuralgia, and at a later period mental anxiety on account of domestic matters was superadded. Quite suddenly the neuralgia ceased to trouble her; but coincident with its disappearance, and replacing it, came the melancholia under which she now labors. She became dull, listless, and apathetic, and the one end and aim of her life seemed to be the termination of it by her own act. Probably she was under the influence of certain delusions even then, but she gave no distinct expression to them for many months—indeed, not till after the occurrence I report, and then only on a very few occasions. Her intelligence remained almost as clear as ever, and this rendered it all the more difficult to take sufficient precautions to prevent her accomplishing the object of her desires. Every effort was made to keep her at home, but several determined and very nearly successful attempts at suicide on her part while there induced her relatives to remove her to an asylum.

For some months after her admission she remained in very much the same state—was dull and listless, but very rational in her conversation and her letters. The close and careful watch kept on her prevented her actually attempting any injury to herself, but there was no reason to believe that the tendency was less strong than before. At last she saw her opportunity. Just after getting into bed she was observed to have become suddenly and violently ill, and medical aid was summoned at once. On its arrival she was found to be quite unconscious, very pale, skin cold and clammy, pupils widely dilated, but there was no conjugate deviation present; the features were drawn and altered, and the head was rolled rhythmically from side to side, patient moaning slightly at times. The radial pulse on the right side was very weak, that on the left almost imperceptible—rate, 78 per minute. The left arm and leg were quite paralyzed, so far as could be made out. The right arm was lifted and let fall feebly and aimlessly now and then. She had vomited a little, but no deleterious substance could be detected in the rejected matter by the rough examination possible at the time.

On palpation over the præcordia, the cause of this rather puzzling condition was discovered. A knob about the size of a large pea was felt adher-

ing to the chest-wall, in the situation of the apex beat, and this proved to be the head of a large steel shawl-pin, about 3⅜ inches long, which the patient had succeeded in secreting, unobserved by the attendant in charge, and which she had thrust right into the chest, at the situation mentioned above, the part embedded being directed slightly upwards and inwards, and measuring about 2¾ inches. It was at once removed, and stimulants administered, and almost immediately the heart's action began to gain in force. The pulse became stronger and steadier, and consciousness slowly and gradually returned. For some time there was very urgent dyspnœa, and patient complained much of pain in the præcordia, but these unfavorable symptoms diminished as time went on, and after an hour had passed she was much better: the paralysis of the left side had disappeared; the pulse was steady, and of fair strength—rate, 108 per minute; and she was quite conscious of what transpired around her. Four hours after the occurrence, she was sick again, and vomited a little; but this soon passed off, and she fell asleep, and slept at intervals during the rest of the night, stimulants being given frequently in small doses. On the following day she complained of some pain at the site of puncture, and of headache, but was otherwise pretty well, and her recovery after this proceeded without interruption. Some months have now elapsed, and no trace of the injury can be detected.

It appears to be practically certain that the pin transfixed the heart, probably at a point very near the apex of the organ. The elaborate analysis of cases of heart wounds in Holmes's *System of Surgery*, vol. ii., pp. 599–610, renders it unnecessary for me to do more than simply to refer to it for a *résumé* of the subject. Perhaps the case alluded to in that article, of the thrusting of a long gold needle into the heart, is the most similar to mine on record, but fortunately the issue here was very different. For the benefit of the curious in such cases, I may be permitted to refer to the ingenious Mrs. Aphra Behn's account, in *Oroonoko*, of the tigress which lived comfortably for many years with seven bullets of lead in her heart. After this, it is not surprising that the authoress should announce heart-wounds to be anything but necessarily fatal.

Perhaps the chief interest of the case recorded here is its bearing on Mr. Westbrook's proposal to aspirate the right auricle in cases of acute and intense pulmonary congestion, with over-distention of the right side of the heart. The part of the organ to be operated on is, of course, different from that involved in this experiment, but it is not quite clear that the results would be less serious; and even Mr. Westbrook appears to prefer to adopt the measure only in cases where all chance of recovery has disappeared. Perhaps other less heroic plans might obviate the disappearance of all chance of recovery. If not, it is doubtful whether it is worth while to torment the last hours of a patient who is already moribund. At any rate, I am convinced that my patient made a very narrow escape—so narrow that I cannot but think cardiacentesis out of the range of practical surgery.

**The Micro-Organism of Purpura Hemorrhagica.**

To the Pathological Society of London (*Lancet*, February 23, 1883), Mr. Watson Cheyne showed micro-organisms from two cases of purpura hemorrhagica. Dr. Russell's case was that of a girl, aged twelve years, who had a purpuric eruption with pain in the joints, epistaxis, and bleeding from the ear. The temperature was 104.6° on the morning of death. There were numerous ecchymoses in the skin, and hemorrhage into the pelvis of the right kidney. Sections of the heart showed extensive hemorrhage beneath the exocardium. The capillaries were plugged with small bacilli arranged in colonies—a few were isolated, the typical mode of grouping was evidently in colonies. The walls of the vessels were ruptured; there was no evidence of inflammation. The bacilli measured $\frac{1}{77000}$ in. in length and $\frac{1}{200000}$ in. in diameter. Spores or unstained roundish areas also existed in the rods. There was no peculiarity in the staining reactions. Methylene blue was the best dye. The distension of the wall of the capillaries seemed to show that the bacilli had been growing in the blood for some time. The probable cause of the hemorrhage was the plugging of the vessels with bacilli. Micro-photographs were shown. Dr. Pye-Smith's case was a boy, aged fourteen, who had one brother who bled much at the nose. The patient bled from a boil at first; afterwards there was constant bleeding from the gums, nose, and also into the conjunctiva. The temperature was 98°. After prolonged use of local styptics the bleeding ceased. The anæmia produced was intense, and the patient died. There was hemorrhage from an erosion of one small ulcer in the stomach. There were small subarachnoid hemorrhages. The testes, lungs, brain, skin, serous and mucous membrances were all affected. The lungs, tonsil, and heart were examined. The pulmonary alveoli were full of blood, and the vessels contained colonies of micro-organisms, the capillaries and some larger vessels were completely blocked with swarms of streptococci which exhibited a typical chain formation. These micrococci were $\frac{1}{70000}$ in. in diameter. There were no free micrococci. No inflammation and no necrotic layer were seen around the plugged vessels. Sections of the tonsils showed several of the vessels plugged with streptococci. The importance of the observation of two cases of idiopathic purpura hemorrhagica associated with the presence of micro-organisms was very great. These micro-organisms formed colonies, other kinds did not form vascular plugs (except the typhoid bacillus). The question whether there was an entrance of specific germs from without, or whether organisms had penetrated into the blood from the alimentary tract, was considered.

Dr. Pye-Smith referred to the fact that no change had yet been found in the blood-vessels of cases of purpura, though such change might be expected to exist.

Dr. Bernard O'Connor asked whether micro-organisms had been found in the blood.

Dr. Angel Money had not found micro-organisms in the blood in two cases he had examined.

Dr. Stephen Mackenzie said we ought not to come to the hasty conclusion that organisms were present in all cases of purpura; and Mr. Cheyne had exercised scientific caution in limiting his in-

ferences to his actual observations. There was no probability of any specific organism being engendered in cases of "iodic" purpura.

### "Chloride of Methylene."

The *Brit. Med. Jour.*, April 12, 1884, tells us that MM. Regnauld and Villejean have published the results of two investigations into the nature and action of chloride of methylene, from which they have drawn several interesting conclusions. They set themselves, in the first place, to determine the relative constitution of the substance known as chloride of methylene in England, as compared with a standard specimen of chloride of methylene ($CH_2Cl_2$) prepared by themselves. The density of the former at 15° C. (59° F.), was found to be 1.363, and of the latter 1.334, which pointed to the probability that the English product was not exclusively composed of chloride of methylene. Further, the standard chloride of methylene boiled at a temperature of 40.4° C. (104.7° F.), while the other did not show any signs of ebullition until 53° C. (127.4° F.) was reached. At that temperature, most of the English substance passed over into the condenser, leaving a residuum which proved to be methyl alcohol. That part which passed over was found to be chloroform. The substance, therefore, known in this country as chloride of methylene is a mixture of methyl alcohol and chloroform, the proportions of each component being one part of the former to five of the latter. The second part of the research was devoted to a study of the physiological effects of chloroform ($CHCl_3$) and of chloride of methylene ($CH_2Cl_2$). It is unnecessary to make any remarks upon the action of the former substance, but the results of the inquiry regarding the latter are novel and interesting. From fifteen experiments upon dogs, the following picture is drawn as giving the typical sequence of phenomena. After half a minute of inhalation, agitation began with whining. After one minute and a half, there was dilatation of the pupils and nystagmus. After two minutes, the eye-reflexes were abolished, and general insensibility set in. In three minutes clonic movement of all the extremities and the tail set in. At four minutes inhalation was stopped and the dog set free. The clonic movements ceased. In six minutes the eye-reflexes returned; there was persistent contracture of the jaws. At seven minutes, there was an epileptiform attack. At eleven minutes the phenomena diminished in intensity: the animal tried to get up, but the paws seemed to be in the same condition as in strychnia poisoning. At twenty-two minutes, the jaws could not be opened; there was convergent strabismus. Up to about half an hour, the symptoms of intoxication gradually passed off, but, although the jaw could be opened, the animal could not raise its head, and paid no attention to its keeper's summons. These results prove that the substance known in this country as chloride of methylene has nothing in common with true chloride of methylene except the name; that the action of the English product is solely due to its contained chloroform; that the effects of true chloride of methylene are entirely different from those of chloroform; and, finally, that the action of the former is so disturbing that it never can be used in surgical practice.

# Reviews and Book Notices.

## NOTES ON CURRENT MEDICAL LITERATURE.

——In a reprint from tho *American Practitioner*, Dr. W. O. Roberts, of Louisville, describes a knife-wound of the intestines, and in passing vindicates the right of Dr. S. D. Gross to the honor of first defining the proper treatment. His words are:

"What Dr. Gross suggested, now more than forty years ago, as applicable to extensive wounds of the gut, has, as is well known, recently been widened so as to embrace all penetrating injuries of the bowel, but the honor belonging to the entire procedure is now claimed by others.

"I submit that it belongs to Dr. Gross."

——The *American Journal of Ophthalmology*, vol. i., No. 1, starts out with an excellent assemblage of articles, and with fine paper and typography. It promises well for the future. Issued on the 15th of every month by J. H. Chambers & Co., St. Louis; editor, Dr. Adolf Alt. Price, $2.50 per year.

## BOOK NOTICES.

**Elements of Modern Chemistry. By Adolphe Wurtz.** Second American Edition. Translated by Wm. H. Greene, M. D. 8vo., pp. 770. Price, $2.50. J. B. Lippincott & Co.

The success of this treatise in France, and the distinguished position held by the author, were sufficient reasons to anticipate a welcome by English-speaking students, and this has been fully realized.

In the present edition, important changes have been introduced in order to represent the modern views of chemical science. Of these we may mention a new classification of the metals in accordance with the present theories of atomicity; observations on the significance of chemical energy; an explanation of the remarkable law discovered by Mendelejeff by which the properties of bodies are shown to vary with their atomic weights according to the theory of periodic functions; and a number of other novelties. Extensive additions have also been made to the sections on organic chemistry. We have no doubt that the treatise will continue to be a favorite text-book with students, and it gives us pleasure to bring it prominently to their notice.

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A WEEKLY JOURNAL,
ISSUED EVERY SATURDAY.

D. G. BRINTON, M. D.,
JOSEPH F. EDWARDS, M. D., } EDITORS.

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### PARTURITION IN CENTRAL AFRICA.

From a most interesting paper on this subject by Mr. R. W. Felkin, in the *Edinburgh Medical Journal*, April, 1884, we can form some idea of how our semi-civilized neighbors in Central Africa pass through that period, which a false and enervating civilization has made so critical to the women of America.

In the Madi district, when a woman thinks that she is near the time of delivery, she abstains from meat, but eats a great deal of vegetable food. She cleans up her hut and sends her children away, and when labor commences she walks around the hut, while a friend places a deep layer of dry sand outside, a short distance from the door. The woman sits down, places her feet against stakes driven into the ground, and clasps her legs, while friends take turns in supporting her back, and in kneading and rubbing the abdomen. The cord is cut at about four inches from the child's body, by a stone knife, as a rule, but sometimes it is bitten. Should it bleed, the woman in charge takes the cord in her mouth and squeezes it between her teeth till all hemorrhage ceases; but it is never tied. The woman is not permitted to eat meat for a week or more after confinement; she suckles the child for two years, and has no connection with her husband for six months after its birth.

In the Bongo district an altogether different custom prevails. A branch of a tree is laid horizontally between two other trees, so that a woman can just grasp it firmly. When the pains come on, she seizes the branch, places her feet apart, and bears down; in the intervals she walks about. The mother and child both receive baths immediately after the completion of labor, the placenta being carried by a woman, who dances before the party, and throws it into the stream as far as possible.

Here, too, another custom is prevalent. A hole is dug in the ground, in which a fire is lit; on this fire a pot is placed, containing a decoction of herbs; the woman squats over this, and allows the steam to moisten and soften the passages. It is held in great repute for making labors easier.

He also notes that a like plan, other plants being used, is very generally adopted by Arab women, and natives married to Arabs, before coitus. It is said to contract the parts, and cause great desire.

Speaking of operative interference, he says:

"So far as I know, Uganda is the only country in Central Africa where abdominal section is practiced with the hope of saving both mother and child. The operation is performed by men, and is sometimes successful; at any rate, one case came under my observation in which both survived. It was performed in 1879, at Kahura. The patient was a fine, healthy-looking woman of about twenty years of age. This was her first pregnancy. I was not permitted to examine her, and only entered the hut just as the operation was about to begin. The woman lay upon an inclined bed, the head of which was placed against the side of the hut. She was liberally supplied with banana wine, and was in a state of semi-intoxication. She was perfectly naked. A band of mbugu or bark cloth fastened her thorax to the bed, another band of cloth fastened down her thighs, and a man held her ankles. Another man, standing on her right side, steadied her abdomen. The operator stood, as I entered the hut, on her left side, holding his knife aloft with his right hand, and muttering an incantation. This being done, he washed his hands and the patient's abdomen, first with banana wine and then with water. Then, having uttered a shrill cry, which was taken up by a small crowd assembled outside the hut, he proceeded to make a rapid cut in the middle line, commencing a little above the pubes, and ending just below the umbilicus. The whole abdominal wall and part of the uterine wall were severed by this incision, and the liquor amnii escaped; a few bleeding-points in the abdominal wall were touched with a red-hot iron by an assistant. The operator next rapidly finished the incision in the uterine wall; his assistant held the abdominal walls apart with both hands, and as soon as the uterine wall was divided he hooked it up also with two fingers. The child was next rapidly removed, and given to another assistant after the cord had been cut, and then the operator, dropping his knife, seized the contracting uterus with both hands and gave it a squeeze or two. He next put his right hand into the uterine cavity through the incision, and with two or three fingers dilated the cervix uteri from within outwards. He then cleared the uterus of clots and the placenta, which had by this time become detached, removing it through the abdominal wound. His assistant endeavored, but not very successfully, to prevent the escape of the intestines through the wound. The red-hot iron was next used to check some further hemorrhage from the abdominal wound, but I noticed that it was very sparingly applied. All this time the chief 'surgeon' was keeping up firm pressure on the uterus, which he continued to do till it was firmly contracted. No sutures were put into the uterine wall. The assistant who had held the abdominal walls now slipped his hands to each extremity of the wound, and a porous grass mat was placed over the wound and secured there. The bands which fastened the woman down were cut, and she was gently turned to the edge of the bed, and then over into the arms of assistants, so that the fluid in the abdominal cavity could drain away on to the floor. She was then replaced in her former position, and the mat having been removed, the edges of the wound, *i. e.*, the peritoneum, were brought into close apposition, seven thin iron spikes, well polished, like acupressure needles, being used for the purpose, and fastened by string made from bark cloth. A paste prepared by chewing two different roots and spitting the pulp into a bowl was then thickly plastered over the wound, a banana leaf warmed over the fire being placed on the top of that, and, finally, a firm bandage of mbugu cloth completed the operation.

"Until the pins were placed in position the patient had uttered no cry, and an hour after the operation she appeared to be quite comfortable. Her temperature, as far as I know, never rose above 99.6° F., except on the second night after the operation, when it was 101° F., her pulse being 108.

"The child was placed to the breast two hours after the operation, but for ten days the woman had a very scanty supply of milk, and the child was mostly suckled by a friend. The wound was dressed on the third morning, and one pin was then removed. Three more were removed on the fifth day, and the rest on the sixth. At each dressing fresh pulp was applied, and a little pus which had formed was removed by a sponge formed of pulp. A firm bandage was applied after each dressing. Eleven days after the operation the wound was entirely healed, and the woman seemed quite comfortable. The uterine discharge was healthy. This was all I saw of the case, as I left on the eleventh day. The child had a slight wound on the right shoulder; this was dressed with pulp, and healed in four days."

Mr. Felkin, rather contrary to have what we

been generally led to believe of these tribes, tells us that so far as he knows, labors are by no means so very easy in this part of the world, and are certainly not the painless, pleasurable affairs which some writers would have us believe. When a hard labor occurs and a woman remains a very long time undelivered, the aid of a man is called in. He, however, uses no instruments; and should he fail, *which, he was informed, hardly ever happens*, mother and child perish, for abdominal section is not in vogue here. He was unable to ascertain what means the man employs to assist delivery.

But the italicized words convey to us the idea that the act of parturition is very seldom a *fatal* act among the semi-barbarous natives of Central Africa.

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### CAPITAL PUNISHMENT.

There can be very little doubt in the mind of any thinking man, that capital punishment is but little better than a relic of barbarism. Experience seems to have demonstrated that the purpose for which it was instituted, that of deterring those contemplating murder from commiting the crime, has not been realized; and the question of abolishing it altogether is being now seriously agitated in England.

When one man murders another he almost invariably does so under the stimulus of passion that makes him for the time being well-nigh irresponsible (though we do not wish to be understood as advocating the much-abused plea of temporary insanity); some real or fancied wrong, or some benefit which he expects to derive from the death of his victim, so works upon his intellect that he is almost, if not quite, irresistibly urged on to the commission of the crime. Or it may be that the deed is motiveless, and in such instances we generally note that the intelligence of the murderer is but little, if any, above that of the brute creation.

On the other hand, when a man has been tried by a jury and convicted, the circumstances are vastly different. Here twelve men, presumably intelligent, and a judge who, on account of his acknowledged intelligence, has been elevated above his fellow men, without the stimulus of passion, revenge, drunkenness, imbecility, or prospective gain, deliberately and calmly direct that another man (the sheriff's officer) shall kill the poor wretch before them. Does this not seem very much like judicial murder, rendered more repulsive from the absence of motive for the act? It is true that the law of the land calls upon these men to perform this dreadful duty: but is it not a barbarous law, that has no good reasons for its existence? Is not the London *Lancet* right when it speaks of "the pitiful and degrading spectacle of a great nation strangling its malefactors like so many dogs?"

Again, it has happened that circumstantial evidence has hanged innocent men, which is a possibility too horrible to be calmly contemplated.

Would it not be better to condemn murderers to imprisonment for life in such a well-built and well-guarded prison that escape would be impossible; to force each man therein to labor at that particular work which observation should have demonstrated to be the most uncongenial to him, and at certain intervals, say weekly or monthly, to march these criminals, heavily shackled and well guarded, through the streets of the city in which they are confined? By thus constantly reminding would-be murderers of the penalty of their crime, we imagine that a much more deterring effect would be realized, than by presenting to them the remote prospect of a tragic and exciting death, preceded by the mistaken, but very general sympathy of the public. To some miserable men the idea of a disgraceful death has no horrors; for to their hardened and brutal natures, *disgrace* is an incomprehensible word, while death, to their irreligious minds, brings but relief from a miserable and wretched life which they prize but lightly.

If, however, capital punishment is a necessity to collective civilized life (which, for the reasons already adduced, we very much doubt), can we not accomplish it in a less barbarous and revolting way than by strangling a man to death or breaking his neck?

That we can, and how to do so, will readily

suggest itself to our readers. We will only mention one plan which seems to us to partake less of barbarism than any other—the hypodermic injection of fatal doses of morphia.

Let us remember that vengeance belongs to a higher tribunal than any human court and jury, and that hanging does not *deter*, and that, therefore, the only two arguments that could be adduced for the perpetuation of this uncivilized procedure are robbed of their potency.

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### CHANCROIDS AND SYPHILIS.

We desire to call attention in an especial manner to the lecture on this subject, which forms the leading article in this week's issue, and to the able discussion which followed.

In view of the wide-spread evil influence of syphilis, both directly as *syphilis*, pure and genuine, and indirectly as the undoubted syphilitic influence upon all diseased conditions, with which every practitioner is familiar, there is no subject before the medical profession to-day that possesses more practical interest than the treatment of syphilis.

Dr. Ashhurst's admirable paper should be carefully read and re-read, as should also the opinions of those who discussed his paper; for they have all had immense experience with this disease, and are well calculated to teach us about it.

The two points upon which the greatest diversity of opinion seemed to exist, are points that will never be positively settled to the satisfaction of all, but will ever remain in dispute, being determined according to the opinion or experience of each individual physician. We refer to the excision of the chancre, and to the institution of immediate specific treatment.

The weight of recorded evidence seems to demonstrate that the excision of the chancre does not tend to prevent systemic infection, yet there are certain good authorities who still advocate it as a prophylactic measure.

The objection which Dr. White urges to the immediate specific treatment has more force from the side of the physician than from that of the patient.

mercury and iodide of potassium possess the power of controlling the poison of syphilis after it has become manifest, it is but fair to infer that they also possess the power to throttle this poison in its incipiency; and as we know that prevention is better than cure, would it not be better to counteract this poisonous influence before it has marshaled its forces to make a savage onslaught on the system?

It is true that by so doing we, in some cases, would never know whether the man would have had syphilis or not; but what difference does this make, if he *does not have it*? As far as losing our guiding point in reference to marriage, there is not so much force in this argument; for if a man comes to us with a primary sore that would make syphilis a dim presumption even, prudence would dictate to us to advise against immediate marriage; and if we institute a course of specific treatment, which, as the speaker says, may *mask* the disease, we can, after the system has become impressed with the drugs, discontinue the treatment, remove the mask, and allow the disease to become manifest, if it has not been controlled or eradicated by the treatment.

The point that strikes us most forcibly is, that we cannot *wait* for developments when we have to deal with such a terrible disease as syphilis.

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## NOTES AND COMMENTS.

### Hot-water Injections in Gonorrhœa.

Dr. S. C. Gordon has had most excellent results from a method of treatment which he thus describes in the *New York Med. Jour.*, April 19, 1884:

I filled a fountain-syringe with a quart of water at a temperature of about 100° F., and, with one of the small tubes introduced into the urethra as high as I could push it, I injected it and allowed it to run back into a vessel. It ran back by the side of the tube, washing the urethra as far as it was thrown up. The first trial acting as a sedative, or at all events giving no pain, I filled the fountain again, this time increasing the temperature about 10°. I found that, by asking the patient to strain a little as if urinating, the urethra could be sufficiently dilated to allow the water to pass into the bladder, and in that way I filled and

refilled the bladder several times, allowing him to pass it off himself each time. The relief afforded by this second injection was immense, and from that moment the dysuria ceased to be an element of much trouble.

This douching I continued twice each day, and in three days I had the pleasure of seeing my patient practically relieved *of all the unpleasant symptoms.* A very slight discharge remained, but a repetition of the same treatment for a few days more completed the cure. From the first day of the injections no anodyne was needed, and no medicine was given. The chordee was relieved, the burning sensation removed, and the patient happy.

In conclusion, he says: "I can give only a brief summary of the cases in which I should expect the most satisfactory results from this mode of treatment:

"1. I should hope, and confidently expect, to abort, in from three to five days, a large majority of cases that were treated as soon as the first well-known symptoms appeared. In these cases I use the injection as *hot as it can possibly be borne*—three or four times in twenty-four hours; at least two quarts should be used at each time.

"2. In cases of ten days' or two weeks' duration (at which time the inflammatory process has ended), I believe the most of the trouble can be relieved in a very few days. The suffering so characteristic of that stage will usually pass away in twenty-four hours. In many of these cases I have been enabled to force the water into the bladder, and then allow the patient to pass it away immediately. This has a good effect upon the dysuria, relieving it almost at once. In this class of cases, also, the water should be very hot.

"3. When two or three days have elapsed before the patient is seen, I do not expect so much as in the former classes. Even here much may be done by the external use of very hot water and the careful, gentle use of the fountain-syringe, filled with *simple warm water*, at about the temperature of the body, or less. This promotes cleanliness, and is a sedative.

"I would add that my three years' experience fully justifies me in commending this plan to the attention of the profession."

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### Two New Cardiac Poisons.

The *N. Y. Med. Jour.*, April 5, 1884, says:

Woorari seems in danger of being outdone as a cardiac poison, if we may judge from the accounts lately given before the Paris *Société de Biologie* of two new Oriental arrow-poisons. A specimen of one of these poisons was presented by M. Bochefontaine, as we learn from a report of the meeting published in the *Progrès Médical.* It was said of this poison that an animal of medium size, wounded with an arrow the point of which had been imbued with it, would make one bound, and then fall dead; and that even an elephant would succumb after running no more than a kilometre. The composition of the poison is not known, being kept a dead secret by the Mois, from whom it was only by subterfuge that the specimen shown at the meeting was obtained. Taken into the stomach, the substance is said to be innocuous. One milligramme injected under the skin of a frog produced death within ten minutes, the heart being arrested in systole, and the reflexes persisting for a time. One of the speakers gave it as his opinion that the poison was probably obtained from the *Upas antiar.*

The other substance, shown by M. Laborde, was termed elephant poison (*poison d'éléphant*), and came from Borneo, where the inhabitants employ it for poisoning their arrows. Experiments on dogs have shown that this substance also kills by arresting the heart's action, but whether in systole or in diastole we are not told.

Two new poisons, then, are before the profession for investigation, and this will have to be directed both to their constitution and their physiological actions. But it must be confessed that the prospect of any notable advantage accruing to therapeutics from such research is remote, while the difficulty of obtaining the substance first mentioned stands in the way of the extended series of experiments necessary before precise conclusions can be arrived at.

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### The Correction of Deformities by Modifications of the Thickness of the Sole of the Shoe.

Before the New York County Med. Ass. (*Med. News*, April 5, 1884), Dr. William Detmold made some remarks, illustrated by diagrams on the blackboard, on the correction of certain deformities in the young by the simple device of thickening the inside or the outside edge of the sole of the shoe, as required. In weak ankles, which were exceedingly common among girls, owing to the breadth of the pelvis, which gave a tendency towards knock-knee, there was always a protrusion of the internal malleolus. This was ordinarily treated by placing a certain amount of stiffening on the inner side of the shoe, and, this failing, by the use of iron splints. The simplest and best way of correcting the deformity, however, was by

making the inner side of the sole thicker than the outer, which had the effect of lifting the weight off of that portion of the skeleton. The same method answered for the correction of knock-knee, but when the child was bow-legged, the thickening was to be placed on the outer instead of the inner side of the sole. If one leg was shorter than the other, there would inevitably result more or less tilting of the pelvis; which had the effect in time of producing lateral curvature of the spine, with its secondary or compensating curvature. This could easily be remedied, when taken in time, by making the sole of the shoe for the foot of the shorter limb sufficiently thick to bring the transverse axis of the pelvis at right-angles to the lower extremities. Dr. Detmold also explained his method of treating flat-foot (which was common in young girls who were poorly nourished and who were obliged to remain in a standing position much of the time), as well as elevation of one shoulder above the other. In five out of every nine young girls, he thought, the right shoulder was a little higher than the left.

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**Malignant Pustule.**

Though comparatively rare, yet this is a most formidable disease, and we should be always ready to energetically combat it. Dr. Wm. S. Janney recently reported some cases before the Philadelphia County Medical Society, and now Dr. A. C. Griffin publishes a case in the *N. Y. Med. Jour.*, April 12, 1884. It was clearly traced to the bite of a fly received in a restaurant.

On making inquiries about the restaurant, it was found that the employees had been in the habit of throwing waste scraps of meat and other refuse into a back yard. This practice having been complained of, it was stopped, by an order from the Board of Health, and for several days afterward the flies swarmed about the restaurant, annoying all by their savageness. So far as could be learned, this was the only person of those exposed whose physical state was in a condition susceptible to the inoculation of septic material, which was undoubtedly conveyed to the blood of this patient by the bite. The fly, which was a common green-bottle or carrion fly, was killed on his cheek by a friend who was dining with him. The fly had bitten sufficiently to draw blood, and it was from this point as a focus that the malignant pustule began its career. That it was a malignant pustule the clinical evidence fully bore out.

He believes that the proper treatment in cases of septic inoculation or malignant pustule lies in the prompt and thorough excision or cauterization of the point of inoculation, endeavoring by these means to prevent the growth and proliferation of the morbid elements, and thus check the absorption of those materials which would contaminate the whole system.

As for general treatment, stimulation should be carried to its fullest extent, and the best of the stimulants will be found to be alcohol. Quinine should be given in large doses to obtain its antipyretic as well as its antiseptic effects. Opium should be administered in quantities sufficient to quiet pain and allay nervousness. The bowels should be kept open by laxatives or mild cathartics. Poultices also seem to give some relief, especially when to them is added some sedative, as tincture of opium.

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**The Treatment of Scalp Wounds.**

In view of the danger of causing erysipelas, inflammation, or suppuration, when the ordinary sutures are used for scalp wounds, we hail with pleasure the suggestion made by a correspondent of the *Lancet* (April 5, 1884), which, while not very new, is yet worthy of repetition:

The scalp is remarkable for the looseness with which it is attached to the subjacent bone, and in simple cuts through the scalp blood and serum can readily force a way between the scalp and the bone, and the accumulation induce suppuration. Still more frequently the scalp is torn away from the skull in a longer or shorter flap, and then, if the edges of the wound are united, the serum effused from the under surface of the detached flap is confined beneath it, and suppuration occurs. If this fact be neglected, suturing scalp wounds is a dangerous step; but if it be recognized and acted upon, the sutures are altogether devoid of danger. The main thing in the treatment of any flap scalp wound, however slight the flap may be, is to secure primary adhesion of the flap to the subjacent pericranium and completely prevent accumulation of serum beneath it. This must be secured by properly-adjusted pressure; and, in view of this primary indication, but secondary importance should be attached to the rapid healing of the edges of the wound. If a good bunch of hair be taken up on each side of the wound, and twisted, and then used as a suture, it is obvious that the whole surface of the scalp from which the hair springs is held compressed against the subjacent skull; and hence this form of suture skillfully employed really fulfils the indications of treatment very well. It is an error to suppose that the tissue of

the scalp is more intolerant of the presence of a suture than the skin of any other part of the body.

### The Incubation of Measles.

Dr. Blenkarne thus writes to the *Brit. Med. Jour.*, April 5, 1884:

Six or seven months ago, J. H., aged about twenty, residing in a neighboring village, where there was not at the time (nor had been for a long time previously) a single case of measles, traveled by train to Brackley, a distance of about eight miles. On looking around the carriage, she found among her fellow-passengers a woman with some children—one, an infant in arms, which had a very red face. On getting into conversation with the mother, she discovered, to her horror (being of somewhat nervous temperament), that the said infant "had 'fell' with the measles" (*alias*, the rash had come out) at Bletchley Junction, *i. e.*, about half an hour before my patient entered the carriage—the other children having recently recovered from the same disorder. Just a fortnight afterwards J. H. returned home, feeling on that day "out of sorts," with coryza, and sent for me the following morning, when I found her with the rash well out all over her face, neck, and shoulders. The complaint ran a mild course. A fortnight exactly after this, her youngest sister (who had not seen her for some time until her return home) caught the infection; the general feeling of *malaise*, etc., occurring on one day, and coming out very freely the day following. In this second case the complaint also ran a mild course, and no other case has occurred in the village up to the present date (March, 1884).

### Syphilis and Locomotor Ataxia.

Dr. Leonard Weber thus concludes a paper in the *Med. Record*, April 5, 1884:

First.—There is not sufficient evidence to show that syphilis may be the direct cause of the typical form of locomotor ataxia, *i. e.*, posterior sclerosis of the cord.

Second.—There is proof, and plenty of it, that syphilis produces certain lesions in the cord and its meninges as readily, if not as frequently, as in the brain. These lesions may be, and often are, followed by symptoms of (atypical) tabes. They are generally relieved by prompt and energetic specific treatment, but rarely cured.

Third.—Experience has shown me that the tendency of the syphilitic virus to produce lesions in the nerve-centres occurs the sooner, the less its action is interfered with by judicious and prolonged treatment, although old cases of syphilis are, *cæteris paribus*, more apt to develop symptoms of neurosis than those of more recent date.

Fourth.—As it has been shown by all observers that syphilitic lesions of the central nervous system once established are seldom really cured by specific remedies, we have additional reason to insist upon timely and long-continued treatment. It is also our duty to impart such information of the nature of the disease to the patient as will lead him to keep a strict and judicious watch over himself, and have suspicious symptoms attended to as early as possible.

Fifth.—I believe a properly graded inunction-cure with unguentum hydrargyri in most cases of syphilis to be the best means of reducing the disease to early and harmless latency.

### Traumatic Rupture of the Trachea.

To the New York Surgical Society (March 11, 1884), Dr. J. L. Little presented a trachea removed from a man sixty years of age who died in St. Vincent's Hospital, having been struck in the neck and upper part of the sternum by one of the shafts of a truck. When he first saw the case, five hours after the injury, he found the patient emphysematous from the head to the lower part of the abdomen. There was considerable ecchymosis over the sternum. No difficulty in breathing. No cough or pain on pressure over the upper part of the sternum and trachea. Had had slight expectoration of blood before entering the hospital. The emphysema was greater over the chest than elsewhere, and less about the neck. Injury of the trachea was suspected. The patient was anæsthetized, and a careful examination was made over the trachea and larynx. But no injury of these parts could be detected, and, as there were no symptoms of suffocation, it was thought best not to perform tracheotomy. He, however, gradually sank, and died this morning, sixty hours after the injury. There was considerable cyanosis during the last twelve hours, but no symptoms of suffocation.

The autopsy showed a complete separation of the fourth and fifth rings of the trachea, with signs of recent inflammation and hemorrhage in the surrounding tissues. Double hypostatic pneumonia and pleurisy also existed.

### Congenital Absence of Femur.

To the Pathological Society of London (March 18, 1884), Mr. Roger Williams showed photographs of a boy, in whom the femora were absent. No trace of the femur or patella could be found on

careful examination on either side; a bony mass in the groin, and apparently articulating with the pelvis, was ascertained to be the head of the tibia somewhat altered. Mr. John Wood said that about twenty years ago, a man who went by the name of the man-monkey was well known in London; the femora were absent, but he was exceedingly agile, and this, combined with the fact that his hands reached to the ground, had earned him his soubriquet. He thought that one moral might be drawn from such cases, and that was how exceedingly useful one section of a limb might be; it was, he thought, an argument in favor of the operation of excision.

## Special Report.

### OPHTHALMOLOGY.—NO. XVII.

BY C. S. TURNBULL, M. D.,

Oculist to the German Hospital, Philadelphia.

**Transactions of the American Ophthalmological Society.**

Nineteenth Annual Meeting, Catskill Mountains, 1883. Published by the Society.

Thirty-eight members were present. Dr. H. D. Noyes, of New York, was elected President, and Dr. W. F. Norris, of Philadelphia, Vice President, and the Society adjourned to meet at the Catskill Mountains, July, 1884.

Twenty-seven papers were presented, as follows, and the amount of interesting material presented serves but to illustrate the interest and energy of this body of working specialists.

Dr. H. Derby, of New York, presented a paper on the "*Influence on the Refraction of Four Years of College Life.*"

So far as his figures go, they tend to show, first, the large amount of myopia, even in this country, among the educated classes. Dr. Loring's combined table of observations, made on the eyes of scholars up to the age of 21, in various countries, gives the German percentage of myopia as 62.10, the Russians 42.8, and the American 26.79. Derby's investigations gave him, among 443 freshmen at Harvard, and Amherst, a myopic percentage of 34; at graduation at Amherst, a percentage of 47.2. It is difficult, however, says D., to compare Dr. Loring's figures with my own, as his statistics were based on observations made between the ages of 6 and 21, and mine between 18 and 23. But all researches made at this latter age go to prove that, at least, or very nearly, one-half of the educated community is myopic, in this as well as other countries.

Moreover, contrary to the impression so long entertained, myopia may be acquired at, or near, the twentieth year, from the same causes that produce it at an earlier age, and may continue to progress until the course of study is completed.

2. "*Some Improvements in Instruments and Appliances for Cataract Operations.*" By Russell Murdoch, M. D., of Baltimore.

3. *A Case of Tubercle of the Iris.* By H. S. Schell, M. D., of Philadelphia.

"The patient, a schoolboy, nine years of age, applied for treatment at Wills' Eye Hospital on August 29, 1881. The eye had been painful for four days, and exhibited the usual signs of ordinary plastic iritis. Treatment was of no avail, and on the following October he was admitted to the Children's Hospital, suffering from well-marked symptoms of coxalgia in the second stage. There was a distinct history of phthisis on the mother's side. The eye was still somewhat painful. There was a ring of circumcorneal injection, the pupil was immovable, the fibres of the iris atrophied, and projecting from the nasal side of the pupillary margin was a small yellowish-white nodule, the size of a pin's head, and tinged with pink. This nodule gradually increased in size. Vision was completely lost in December, and in May, 1882, the anterior chamber was nearly filled with the new growth. The nodule was of a yellowish tinge, and a few minute blood-vessels could be seen upon its surface. At this time the intraocular tension was increased, and the eye was tender on pressure, but not otherwise painful. (An accompanying colored lithograph represented the external appearances quite accurately.) In the meantime an abscess had formed on the outer side of the thigh. It was aspirated by Dr. Ashhurst, and twenty-four ounces of pus withdrawn. The abscess rapidly refilled, and opened spontaneously at the point of puncture a week later. A diagnosis of tubercle of the iris was made, and on May 30th I enucleated the eye, with the hope of preventing the extension of the disease. Healing progressed without obvious incident. The discharge from the thigh gradually decreased, ceased in July, and the boy was discharged from the hospital in September with very good movement of the hip, and but slight shortening. The excised eye was placed in Müller's fluid, and a microscopic section subsequently examined by Dr. Geo. B. Laurason, of New Orleans. He reports that the specimen shows two or three tubercular masses imbedded in a mass of organized inflammatory product. There is one small round tubercle in the left ciliary region, and in front of the iris an oblong tubercular mass is seen,

containing three or four plugged-up blood vessels. The tubercles seem to have developed in the organized inflammatory product, which nearly fills the anterior and posterior chambers."

4. Also, *A Case of Tuberculosis of the Ciliary Body and Iris.* By O. F. Wadsworth, M. D., Boston. Child aged three and a half, was sent to me by Dr. H. Derby for consultation, on October 24th, 1882. Dr. Derby wrote: "I first saw this eye October 4th. The process had then lasted two weeks. It seemed to be a kerato-iritis, as well as I could make out. The question was as to glioma or irido-choroiditis. The father stated that both he and the mother were in good health; and there were two children older and two younger than this one, the oldest seven years, all well. 'Never a doctor in the house with any of them.' These statements as to the health of the family were found later to be quite incorrect. I found, as had Dr. Derby, that it was very difficult to obtain a view of the eye. Even when the patient was held and the lids forcibly opened, the rolling up of the eye and the great flow of tears prevented a satisfactory inspection. The lids were natural; the cornea hazy; the conjunctiva of the bulb moderately congested, but no very marked ciliary congestion; the anterior chamber of good depth; pupil moderately dilated; the upper portion of the iris apparently thickly set with vessels; a yellowish reflex from the pupil. My diagnosis wavered between glioma and irido-choroiditis, as I suggested to Dr. Derby the advisability of an examination under ether before advising enucleation. Both Dr. Derby and I believed the growth to be a glioma. The eye was enucleated the same day by Dr. Derby, placed in Müller's fluid, and given to me for examination. Microscopic examination showed the greater part of the solid mass to be mainly made up of granulation tissue, varying in different parts, here containing closely-packed small cells, there mostly consisting of fibres running approximately parallel—the latter most numerous at and near the anterior border, and now and again broad bundles of the fibres curved forward to the posterior surface of the cornea. Through the mass ran large vessels, and there were remains of many hemorrhages. The pigment, irregularly scattered, was for the most part all that could be made out as remainder of the normal tissues of iris or ciliary body. Throughout this tissue, except in the more fibrous portions, were scattered rounded agglomerations of cells, more deeply stained by hæmatoxylin, and showing the characteristic cell-forms and arrangement of tubercle; giant cells containing many nuclei, surrounded by epithelioid and small granulation cells. The posterior layer of the mass was much more free from cells, and appeared to consist of the infiltrated and thickened remains of the vitreous. In this was seen also, in the sections, the collapsed and folded lens capsule, lined here and there for a short distance by what seemed to be its degenerated epithelium, and containing apparently some debris of lens fibres. One-half of the globe was given to Dr. H. C. Ernst, then engaged in the investigation of the bacillus of Koch, and although the fact that the eye had been in Müller's fluid made the search more difficult, he was able to demonstrate satisfactorily the presence of the bacillus in the specimen. Until the result of the microscopic examination was reached, there had been no suspicion of the tuberculous nature of the disease. This was the first case of the kind either Dr. Derby or I had seen, and the family history, as given by the parents, gave no indication that such disease was at all likely. Indeed, looking back now, with the knowledge of the true nature of the case before me, I am unable to recognize anything in the visible appearances of the growth when I saw it, or in the history of its course, by which it could be distinguished from a glioma, unless, perhaps, the great vascularity of the iris which preceded the development of the growth into the anterior chamber may be regarded as of some value for the differential diagnosis.

The statement that the child herself and the whole family had been free from anything pointing to tubercle, made the case one of much interest to follow. The child continued in apparently good health for more than five months after the enucleation; then for five or six weeks she complained of headache, not enough to lead the parents to call a physician; suddenly became worse, and Dr. Ferguson, who was called, found her in convulsions. She died three days later, with the diagnosis by Dr. Ferguson of tubercular meningitis. There was no autopsy. It was only some time after her death that I learned from Dr. Ferguson that he had attended the family for several years, that the child's father and brother of the father had phthisis, and that the children had been subject to bronchial attacks."

5. *A Personal Experience with Prismatic Glasses.* By S. F. McFarland, M. D., Oxford, N. Y., who says: "Opinions are so various in regard to the efficiency of prismatic glasses in correcting or alleviating the distressing annoyances resulting from muscular pareses, that he gives a brief statement of long personal experience in the use of them." (Pareses of the ocular muscles are, as a rule, too

carelessly noticed, and carefully-adjusted prisms prove a boon to many an aching head. Especially is this the case in near-sighted people. In such, the centering of the glasses is everything as regards the comfort and ease of fit, and opticians cannot be too carefully watched in the adjusting of frames. There should really be a special decentering as carefully ordered as the glasses the oculist may prescribe, because of the frequent occurrence of pareses, as well as peculiar conformation of the orbits.)

6. *On the Apparent Curvature of Surface Produced by Prisms.* By O. F. Wadsworth, Boston.

7. *A Case of Sympathetic Neuro-retinitis.* By James A. Spalding, M. D., Portland, Me.—"the peculiar point of interest being that contrary to the opinion expressed by Mauthner, who 'would not like to enucleate in a case of sympathetic neuro-retinitis,' the right eye was enucleated to relieve the pain from which the patient was suffering. The operation was followed by excessive hemorrhage, which could not be checked by pressure or hot water, and only ceased after ligature of one artery deep in the orbit, and of a second which appeared to spring from the band of connective-tissue uniting the globe and upper eyelid. The case now proceeded favorably, and the patient was sent home in ten days with the vacant orbit in a promising condition. Owing to my desire to see what influence the enucleation of its fellow would have upon the better eye, I abstained from all medical treatment. The result appeared to justify my opinion of the truly sympathetic nature of the neuro-retinitis, for sight gradually returned to the remaining eye. The pain in the head disappeared with considerable rapidity.

"Three months later, he saw the patient again, and examined her with the ophthalmoscope. Left eye normal, pupil active, media transparent, retina and optic papilla normal; the only abnormity consists in the presence of slight tortuosity of the same vein, which was previously mentioned as projecting into the vitreous. Vision $\frac{20}{30}$ and Snellen $1\frac{1}{2}$ with ease, with convex 16 (2, 5, D.)."

8. *Report of Thirty-five Cases of Cataract Extraction.* By David Webster, M. D., New York.

9. *Notes on Ocular Therapeutics.* By W. W. Seely, M. D., Cincinnati, O.

"The first point I desire to notice is in the use of the yellow oxide of mercury in external ocular troubles. Probably every one has found the use of this remedy, whether in corneal or conjunctival diseases, like calomel in the past, often attended with pain. This often-recurring fact and disadvantage led me some time ago to institute some investigations in regard to the cause or causes.

"So far as regards the strength of the preparation, I have found that ten grains to the ounce of the vehicle is the best for all purposes. When I began to inquire into the mode of action of the yellow oxide, I found that this preparation was regarded chemically as an insoluble substance. My theory in regard to its action at first was, copying from the supposed action of calomel, that a chemical change occurred; but finding that it was an insoluble substance, and hence inert, this explanation seemed to fail.

"I took a large number of specimens and had them analyzed, and found that all the so-called 'chemically pure' preparations contained more or less bichloride, and the inference from this was that its action depended on this residuum in its manufacture.

"My assistant, Dr. Caldwell, has lately been working at the subject, and is satisfied that there is a certain amount of solubility in the yellow oxide, to what degree tests have not decided.

"One point seems settled—that the less bichloride a preparation contains, the less the pain produced by the salve, efficiency remaining the same.

"I desire to add one more practical point in the use of the yellow oxide and vaseline, as devised by myself some years ago, in conjunctival affections. Those who have used this combination have doubtless found that in cases where there is a profusion of tears the salve is so quickly washed out that little or no benefit results. In such cases I substitute eserine or the bichloride in solution to contract the blood-vessels. The strength of the bichloride solution that seems to answer every purpose, is one part to seven or eight thousand (one grain to sixteen ounces water), or about one-third the strength preventive of the growth of the bacteria of ordinary decomposition.

"Such a solution, entirely painless, has often, in my hands, set aside an acute catarrhal conjunctivitis of violent type, after one to three or four thorough drenchings of the conjunctiva.

"This is the strength I have used for a long time as an antiseptic in various operations.

"I merely state this to introduce a point I regard of great practical importance. In my hands, one thorough application of a four-grain solution once a day acts altogether better than more frequent applications, either of the same solution, or of weaker ones. This remark applies to all classes of cases.

"One point more in regard to eserine. For the

reduction of intra-ocular tension, eserine has for me entirely done away with paracentesis, and for so long a time and so completely that this procedure has really only an historical interest."

(*To be Continued.*)

## CORRESPONDENCE.

### On Blood-letting as a Specialty.

EDS. MED. AND SURG. REPORTER:—

I have been reading Dr. Corson's recent articles in your journal in regard to blood-letting in the young and old, and in that connection I have referred to some old files of the REPORTER, as I frequently do, and I noticed several well-written articles on the subject of blood letting in pneumonia, but none that seemed to me to be of so much practical importance, or so little tinged with self-laudation, as the one from the pen of Dr. W. G. Bronson, of New Canaan, Conn.

The communication from Dr. Bronson has the true ring, certainly; and I have no doubt it met with a hearty amen from those of the profession who are not wedded to hobbies of their own. I have always read everything from the pen of Dr. Corson with interest, for he writes vigorously and well, and his half century and more of practice is more than the vast majority of physicians attain to.

I well remember his communication some years ago in regard to the ice treatment in scarlet fever; then a few years later one on the use of the forceps in labor; then followed an article on the use of the lancet in pneumonia, with the one above mentioned on bleeding in the young and old.

Being young in the profession when the first article appeared, I eagerly imbibed the idea there set forth, that no child would or could die with scarlet fever when ice was used. I felt myself able to cope with the dread disease in any form. But alas! how many times since have I seen the darlings of many a family ruthlessly cut down, in spite of ice and everything else that could be tried. If Dr. Corson has ever passed through an epidemic of scarlet fever such as I have several times—and he certainly has—he must have seen times when the hand of death was upon the little sufferer from the very first moment; when ice nor veratrum, nor quinine nor stimulants, delayed for the briefest period the monster.

How idle and ridiculous it seems, then, for any one, even with Dr. Corson's experience, to claim that any particular treatment will cure every case. Since I have been a subscriber to your journal, a great many specifics have been proclaimed by different parties for diphtheria, but when tried on a malignant case, had no effect at all. I have recently had several cases of pneumonia, one of which was a regular "typical case," such as is mentioned by Dr. Corson, in his communication several years ago. But, strange as it may seem, although the patient presented the identical symptoms mentioned by Dr. C., I did not bleed, for I did not consider it necessary. Blisters, opiates, veratrum—which Dr. C. condemns so much—stimulants and good food, brought the patient around nicely, along with other "typical cases" under same plan of treatment.

Do not understand me as condemning the lancet. Far from it. It should be used like any other powerful remedy—whenever it is necessary—but only when, in the opinion of a fair-minded physician, it is the best thing to do. I am opposed to indiscriminate bleeding by inexperienced persons.

A young practitioner, reading Dr. Corson's communication, would think nothing more was required than a good bleeding; and failing to diagnose correctly, would use the lancet without judgment, or reason, or necessity. Dr. Bronson well says, that the gravity of pneumonia depends, largely, on its character, age, etc., and that a great many will recover without *any* treatment. We all know that to be true; and we know equally well that some will die, no matter how much they are bled, as Dr. B.'s two cases did; and it would seem hardly possible for Dr. Corson not to have lost some of his patients, even after he had taken a pint or so of blood from them, although he does not mention any such loss. However, when I began this communication, I intended to say something about bleeding in the young and old, *in re* Dr. Corson's recent articles on those subjects.

It is barely possible that in certain conditions of new-born children, bleeding would be called for; but, in a practice of twenty years, I can not think of a single instance in which I have the slightest idea that a child could have been saved by that means. Suppose, taking any one of Dr. C.'s "typical cases," in which he considered blood-letting necessary, he would have plunged the child into a warm bath, with other appropriate and suggestive treatment, would not the result have proven just as satisfactory? What possible benefit can be derived from taking blood from a child, with any and every infantile ailment, as Dr. C. evidently teaches, is more than I can understand. There are cases, certainly, when it would be beneficial; but since the wisest of our profession do not pretend to be able, at all times, to tell what ails a child, how are we to know when to bleed? Indiscriminate bleeding here would surely be more reprehensible than in adults.

In all the cases presented by Dr. C., after a careful reading, I can find nothing in the result to advocate the utility of it. Notably in the case of stramonium poisoning, while virtually admitting that it did no good, he says it did no harm. That seems to be begging the question, it is the *good* he is after, else where is the necessity of bleeding at all?

Dr. C. has a long article on blood-letting in the old, and presents quite a number of "typical cases." When you read of one, you have a sample of the whole—some, of course, being spare and thin, others stout, all feeling about the same way—dull, languid, headache, etc. I except, of course, any who may have presented apoplectic symptoms, in which case bleeding is always eminently proper. All these old people had been in the habit, doubtless, of being bled every spring, most likely some of them in the fall too, and blood-letting was the sovereign balm for all their ills. Allow me to say right here, that in the good old days, of blood-letting in the community in

which I practice, here and there an old man in the country had his lancet, and all the old folks got bled spring and fall as regularly and punctually as they sheared their sheep or pulled their beans. I can, at random, select any old person, and ten to one, if he or she is over sixty years of age, there will be so many cicatrices in the region of the median cephalic vein that an experienced bleeder like Dr. C. could hardly find a place for his lancet. My father and mother were both believers in, and practicers of, this useless habit; and I well remember how frequently, in my younger days, the lancet would be called into requisition, sometimes by an old doctor in the neighborhood, but oftener by any old farmer who happened to have a good one. My mother's arms, at the bend of the elbow, were both actually so cut and hacked by the lancet that I think it would have been impossible to bleed her from either arm. My father's were not quite so bad. Both have requested me frequently to bleed them; but they managed to live comfortably for twenty years at least without their customary loss of blood, and both died a year or so ago, the one long past four score, the other nearly that. There are plenty of old people in this neighborhood who are past four score, and who have not been bled for twenty years, and they sensibly conclude they don't need to be.

Returning to Dr. C.'s cases, we will take the case of the old lady ninety-one years old, in her second childhood. Suppose the doctor had given her a *placebo*, if such a term could be applied to blood-letting, that is, bled her to about ten drops, instead of as many ounces, and made her believe it was a good deal—will he say it would not have done as well? She no more needed to be bled to any extent—than she needed the latest fashionable bonnet. The fact he mentions in regard to the ages of some parties who were bled, argues nothing in favor of blood-letting, but rather in favor of the superior sanitary and dietetic regulations of to-day, as compared with fifty years ago. People live longer in every community to-day than they did fifty years ago. Men were considered very old who reached sixty-five or seventy; now such ages, and much greater, are common. I hope those good old remedies, the lancet, opium, and calomel, will never go out of fashion. There are times and diseases in which they, or some one of them, are our sheet-anchors; but because this is so, is it any reason why they should be used in season and out of season? And are we to learn nothing as we go along? Is our science to make no progress corresponding with everything else? There are medicines in use to-day which were never thought of when Dr. C. commenced to practice, and which we could hardly do without; but while this is so, we need not entirely discard our old friends. We can use them when necessary. Opium has not, and never can have, a substitute, and the same can be said of calomel and the lancet; only let us not abuse the use of any of them, any more than we would or should any of our later remedies. To argue that blood-letting is the only remedy in every case, is to argue against light and knowledge, notwithstanding the able advocates of the practice in the person of Dr. Corson and others.

WM. F. MITCHELL, M. D.

*Addison, Pa., April* 7, 1884.

# NEWS AND MISCELLANY.

### American Climatological Association.

The programme of exercises at the first annual Congress of the American Climatological Association, to be held at the Hall, northwest corner of Sixth and F streets, Washington, D. C., on May 3d and 5th, 1884, (sessions 10 a. m. and 3 p. m.) is announced as follows:

*Papers:* 1. Opening address, F. I. Knight, M. D., Boston, Mass. 2. "The Etiology of Pulmonary Phthisis," B. F. Westbrook, M. D., Brooklyn, N. Y. 3. "Dryness and Elevation the Most Important Elements in Climatic Treatment of Phthisis," Chas. Denison, M. D., Denver, Col. 4. "Some Observations on the Diagnosis of Pulmonary Diseases," D. N. Kinsman, M. D., Columbus, Ohio. 5. "The Effects of Humidity on the Cause and Course of Diseases," W. H. Geddings, M. D., Aiken, S. C. 6. "The Effects of Sea Air on Diseases of the Respiratory Organs," Boardman Reed, M. D., Atlantic City, N. J. 7. "The Use of Compressed and Rarefied Air, as a Substitute for Change of Climate, in the Treatment of Pulmonary Diseases," J. Solis Cohen, M. D., Philadelphia, Pa. 8. "The Constituents of Climate and Their Relation to Disease," J. Hilgard Tyndale, M. D., New York. 9. "The Relation of Laryngeal to Pulmonary Diseases," F. H. Bosworth, M. D., New York. 10. "The Climate of Large Cities Dangerous to Consumptives," Frank Donaldson, M. D., Baltimore, Md.

The above is a list of the papers already reported to the Committee. Others have been promised, but the titles have not been sent in. The order of reading will be arranged at the time of the meeting.

### A New Surface Thermometer.

At a recent meeting of the Société Médicale des Hôpitaux, M. Paul exhibited a new form of surface thermometer of simple construction. The instrument consists of a straight stem and a spiral coil, which are connected to one another by a short junction at right angles to the direction of the straight stem. This essential part of the thermometer is enclosed in a covering of caoutchouc, which has the shape of a shallow hat or cupping-glass. In communication with the internal cavity of the hat is a hollow tube, provided with an elastic pear-shaped bag. When the latter is emptied by being squeezed, the open, somewhat funnel-shaped end of the hat is applied to the skin, and on relaxing the pressure on the elastic bag, the instrument becomes affixed by the atmospheric pressure.

### American Surgical Association.

In our next issue we will give a report of the proceedings of the American Surgical Association, which met in Washington, April 30, May 1, 2, 3.

### The American Medical Association.

The Pennsylvania Railroad Company has fixed the rate of fare for delegates at $9.80 from New York to Washington and return, $6.10 from Philadelphia to Washington and return, and $1.65

from Baltimore to Washington and return. Limited round-trip tickets can be obtained, for these prices, at any of the offices of the road, on presentation of credentials.

### Items.

—It is said that the recent flood has improved the health of Cincinnati by cleansing the unhealthy districts.

—Prof. A. Vercelli performed nephrectomy, in Milan, on March 10, for carcinoma of the kidney. The patient died in five hours.

—A case of chromidrosis (rose color) was shown by M. le Roy de Méricourt at the meeting of the Académie de Médecine on March 25.

—The New York State Assembly has passed a bill prohibiting the sale of drugs by any other persons than pharmacists and physicians.

—Prof. Alfred Stillé, after twenty years' service as a teacher, delivered his valedictory address to his class on April 10, his resignation, as announced at the beginning of the term, taking effect at the close of the session.

—Dr. H. H. Seelye, who recently completed his term of service on the house staff of Bellevue Hospital, has been appointed instructor in physical education at Amherst College, succeeding Dr. Hitchcock, who goes to Cornell University.

—Dr. Robert Wright, the oldest graduate of West Point, died at Centreville, Md., April 21, aged eighty. The doctor had served his country faithfully for many years, and had held many positions of public trust in Maryland, his native State.

—The bill defining the titles and duties of army medical officers of the higher ranks has passed the Senate. Surgeons with the rank of Colonel are to be styled Assistant Surgeons-General, and those with the rank of Lieutenant-Colonel, Deputy Surgeons-General.

—The French Government is reported to be preparing a system of quarantine and inspection of vessels arriving from infected ports, in view, it is said, of the present prevalence of the disease in India. A London dispatch dated April 23 reports the arrival of an English ship at Alexandria, Egypt, from India, with a case of cholera on board.

### OBITUARY NOTICE.

### DR. WILLARD PARKER,

The distinguished New York physician, whose health has been gradually failing for the past six months, died April 25. Dr. Parker was 83 years old, and had been a practicing physician over fifty years. He was born in Hillsboro, N. H., on the 2d of September, 1800, his ancestors on both sides being English Puritans, who came to Massachusetts in 1640, and settled at Chelmsford. They were active farmers, and more than one member of the family became distinguished in the revolutionary war. Willard Parker was a farmer's boy, working from sunrise until sunset on his father's possessions. At 19 he had fitted himself as a teacher, and, by diligent study, prepared himself for Harvard College, where he was graduated in 1826.

He then began the study of medicine in the city of Boston, and later he went to Woodstock, Vt. In 1830 he was appointed to the chair of anatomy in the Berkshire College, at Pittsfield, Mass. In 1836 he accepted the chair of surgery in the medical college at Cincinnati. Soon afterward he went abroad, and spent some time in the French and English hospitals. Ill health forced him to leave the West on his return, and he was appointed to the chair of surgery in the College of Physicians and Surgeons in New York city. His life since then has been one of peculiar devotion to the interest of his profession.

In 1856 he was appointed visiting surgeon to the New York Hospital. In 1865, on the death of Dr. Valentine Mott, who was then President of the New York State Inebriate Asylum, at Binghamton, Dr. Parker was appointed his successor. In 1870 Dr. Parker resigned the active duties of his professorship of surgery in the College of Physicians and Surgeons, becoming Emeritus Professor of Surgery. In the same year he received the degree of LL. D. from the College of New Jersey at Princeton. He was consulting surgeon to the New York, Bellevue, St. Luke's, Roosevelt, and Mount Sinai Hospitals, and the Home for the Ruptured and Crippled. He was a member of the New York Medical Society, American Medical Association, the New York County Medical Society, the Academy of Medicine, the Pathological Society, the New York Medical and Surgical Society, and the Society for the Relief of the Widows and Orphans of Medical Men. He was an honorary member of many other societies.

### QUERIES AND REPLIES.

EDS. MED. AND SURG. REP.—

I would like to ask, through the REPORTER, what the most successful treatment is for pruritus ani? Also for the treatment of oxyuris vermicularis? I hope to hear of something that will be better than anything I have found as yet for the treatment. E. R. S.

*Metz, Ind., April* 7, 1884.

### MARRIAGES.

BULLARD—HUPP.—At the First Presbyterian Church, Wheeling, W. Va., Wednesday afternoon, April 23, 1884, at three o'clock, by the Rev. Dr. Cunningham, Dr. R. H. Bullard and Miss Annie L. Hupp, daughter of Dr. John C. Hupp. No cards.

LYLE—ALEXANDER.—At the home of the bride's mother, in Belleville, Pa., Wednesday evening, April 9, 1884, by the Rev. T. R. Alexander, Dr. John W. Lyle, of Washington county, Pa., and Ada E. Alexander, of Belleville.

SWIFT—GRIFFITHS.—At St. Paul's Church, Des Moines, Iowa, Wednesday, April 16, 1884, by the Rev. W. H. Van Antwerp, Lawrence Chew Swift, M. D., formerly of New Brunswick, N. J., and Miss Mabel Bruce Griffiths, daughter of Colonel Joseph M. Griffiths, of Des Moines, Iowa.

### DEATHS.

CUYLER.—At his late residence in Morristown, N. J., on Saturday evening, April 26, 1884, Dr. J. M. Cuyler, Brigadier-General in the United States Army.

PARKER.—At his residence, in New York city, Friday, April 25, 1884, Dr. Willard Parker, in the eighty-fourth year of his age.

WEATHERBY.—In this city, April 20, 1884, Joseph C. Weatherby, M. D., in the seventy-second year of his age.